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Journal of the Missouri State Medical Association
January 1999

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- ☐ MSMA 1999 Annual Convention Preliminary Program
- ☐ The HeartMate Left Ventricular Assist System: First Successful Implantation in Missouri
- ☐ Emergency Medicine Quiz

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On the Cover: "Garden in Snow" - by Henry Domke, MD. This started as a slide that Dr. Domke took at the Missouri Botanical Garden in St. Louis. There was a fresh snow and the Japanese Garden was almost empty. The white of the snow added dramatic contrast to the vegetation. Using a computer, Dr. Domke used the program Painter to draw Impressionistic brush strokes. Dr. Domke's art can be seen at Legacy Art, 1010 East Broadway in downtown Columbia or on their website: legacyart.com.

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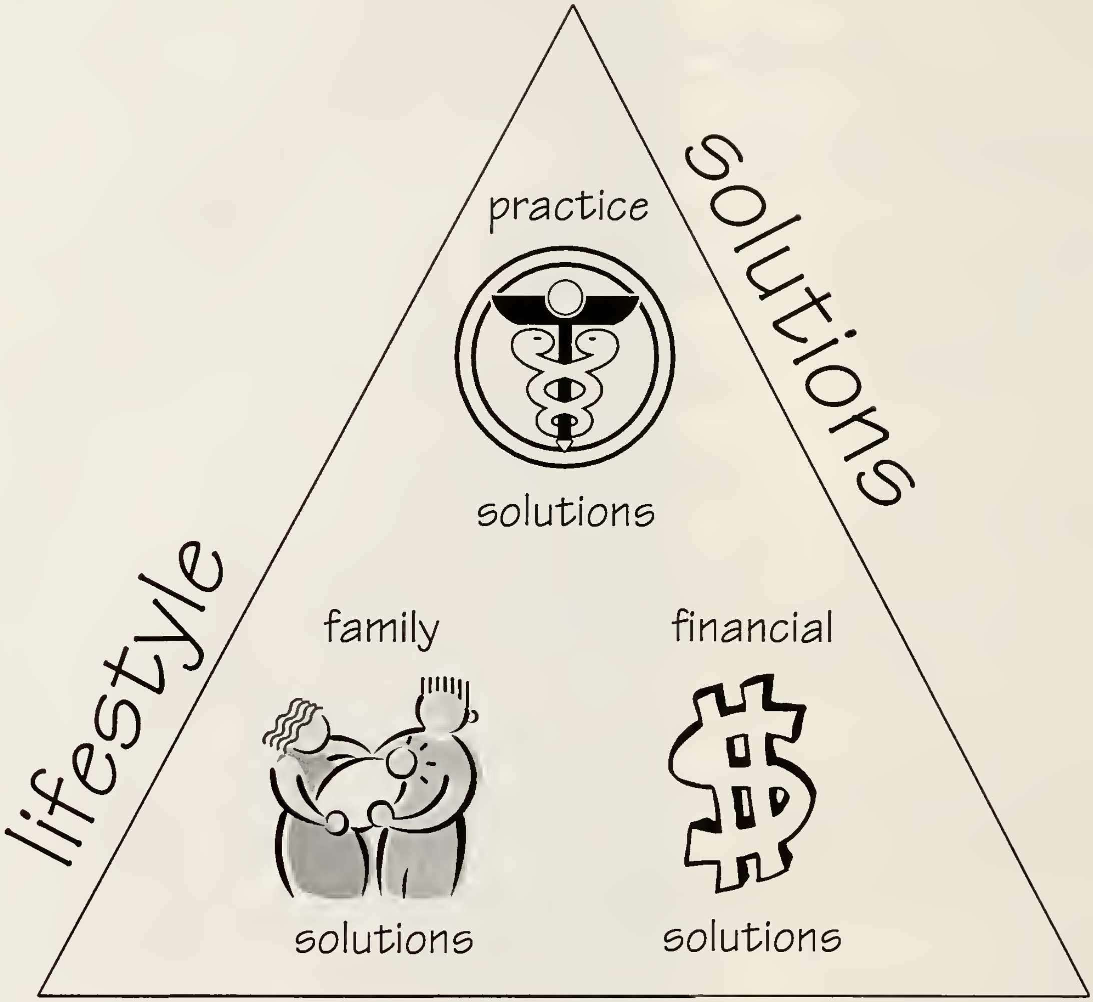
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Fargo, Hawaii

J. Regan Thomas, MD

I'm writing this month's "Editor's Desk" column as I return from the 1998 Interim Meeting of the American Medical Association. The meeting was held in Honolulu this year and it struck me that many people, due to that location, may think their delegates were "vacationing." Although most will admit they prefer even the long flight to Hawaii to a shorter flight to somewhere less glamorous (say Fargo, North Dakota), there was more work than play associated with the meeting for our delegates, alternate delegates, and staff. I thought it would be useful to give our membership some insight to the activities of the AMA delegation.

First, there are preliminary meetings here in Missouri to prepare for the AMA including development of resolutions to be sponsored by Missouri and presented to the AMA House of Delegates. The resolutions from each state and specialty group are then compiled and mailed to all delegates and alternate delegates for review and consideration before the meeting. Twice a year several hundred resolutions and reports are considered as business of the AMA House of Delegates. This meeting was typical with a resolution book approximately five inches thick and weighing a good 10 pounds or more. Each of these items is discussed, debated and eventually voted upon. The discussion and debates are held at multiple forums, both formal and informal.

Each morning the work day begins at 6:00 - 6:30 a.m. with a breakfast meeting (uniformly bad hotel food whether it's in Honolulu, Dallas or Chicago). Missouri now meets jointly with the other states that make up the Heart of America caucus. Our caucus partners include Oklahoma, Kansas and Arkansas. Many states form similar caucus groups to enhance their clout as a voting force on issues or candidates for office. These meetings break up at 8:00 a.m. to 9:00 a.m. so participants can attend the House of Delegates meeting or on Mondays to attend the various reference committees.

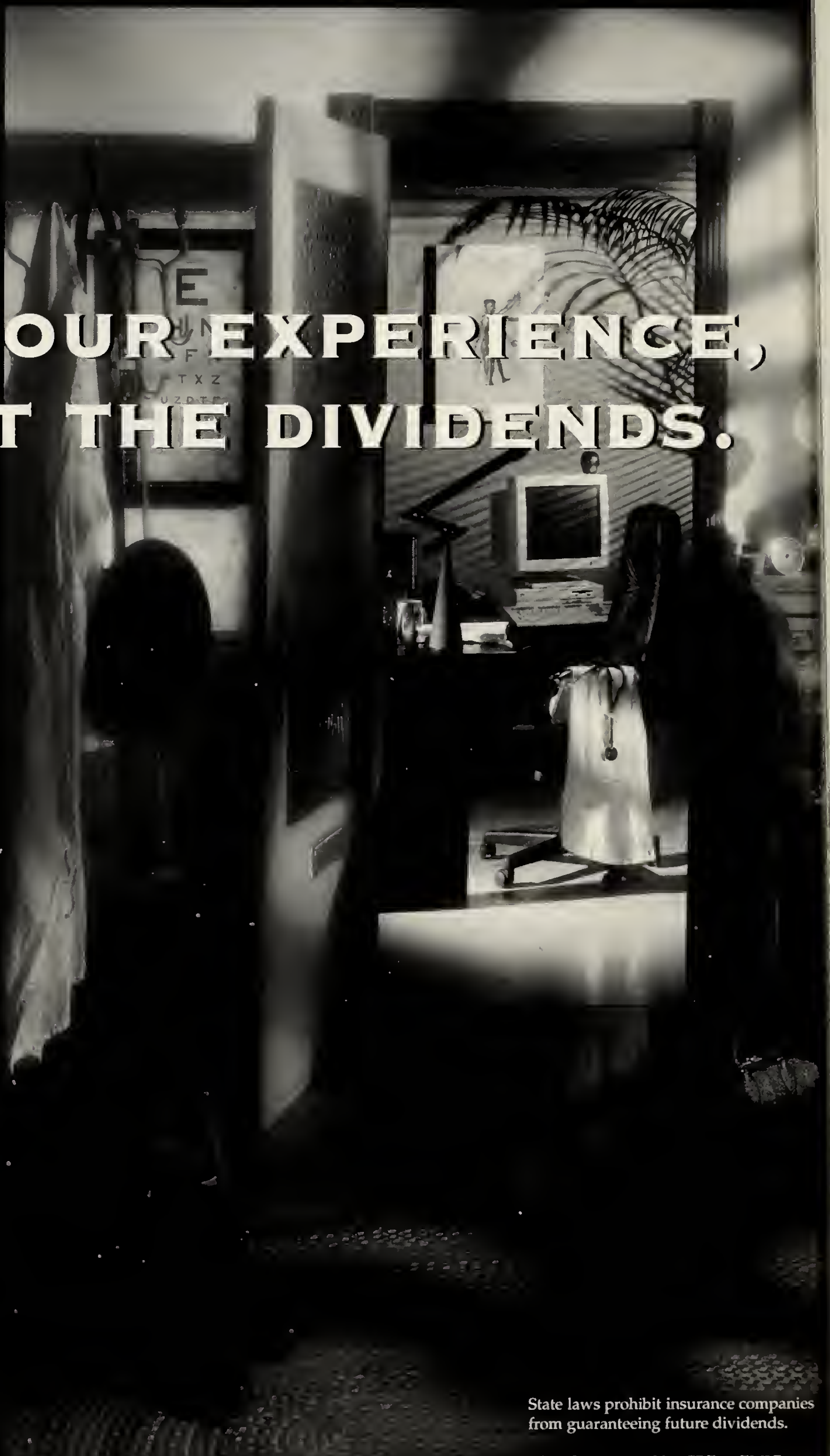
Each of the Reports or Resolutions are referred to a reference committee based on the topic. Here, any credentialed individual can present their views on a resolution. The reference committee then discusses the resolutions and makes recommendations to the House of Delegates at large. The reference committees typically last until 4:00 p.m. to 5:00 p.m. Frequently, some of our delegation serves on one of these reference committees and their discussions as a small group typically last late into the evening.

Tuesday and Wednesday (and Thursday during the June Annual Meeting), following the morning Heart of America caucus, the entire day is spent in the House of Delegates. Typically there are then late afternoon or early evening Missouri caucus meetings to discuss the day's events and plan for the following day.

Our MSMA staff is busy coordinating all these events and supporting the delegate's activities. They are also interacting with their counterparts from other state delegations or AMA staff as required. This includes some evening events such as this year's dinner honoring the retirement of Hugh Stephenson, Jr., MD, from the delegation after 36 years of service.

The reality is that our AMA delegates and alternate delegates put in long hours of dedicated work representing our membership during the AMA meeting. Our MSMA staff works equally hard at facilitating the needs of the delegation. Although travel expenses and a per diem are reimbursed to the delegation, they have donated much in the service of MSMA. Each one has given not only their effort and energy, but time away from their practice and home.

Full days and activities that start early and end late make up the AMA meeting. Sometimes you can't tell if you are in Honolulu or Fargo, except for the jet lag. MoMed



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Congratulations

Dear Regan,

I am writing to congratulate you and Tom Eppright on the delightful "Profiles in Medicine" which appeared in the December issue of *Missouri Medicine*.

I thoroughly enjoyed reading the interview that Tom Eppright conducted with Paul Meyer and Stanley London, and it occurred tome that this style of presenting interesting material was very effective, at least for me.

While I always enjoy each issue of *Missouri Medicine*, it is sometimes a challenge to stay focused on articles that are presented in the standard format.

The interview format on the profile on sports medicine was entertaining, interesting and informative!

Thanks very much for this variation from standard fare.

Best personal regards,

Lester R. Bryant, MD, ScD
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Join Us at the Alliance Day at the Legislature!

The Alliance Day at the Legislature is a unique opportunity for Alliance members to discuss important issues affecting medicine with elected officials.

Tuesday, February 23, will begin with delivering invitations to the legislators and encouraging them to come visit the next morning. Afterwards, there will be a Mid-Winter Board Meeting and you can expect to find some new and unique items at the AMA Foundation Boutique. That evening at dinner, MSMA lobbyist, Tom Holloway will review some of the "hot" legislative issues that members will want to discuss with their legislators.

On Wednesday, February 23, be prepared to make MSMA's legislative voice heard as you visit with the legislators. You'll also have the opportunity to observe sessions in the House and Senate or visit your legislator's office.

After leaving the Capitol, we'll take a tour of the Cole County Historical Museum which occupies a building constructed in 1871. The Museum houses a collection of inaugural ball gowns of Missouri's former first ladies among other notable memorabilia. Then it's off to the Governor's Mansion for a delicious lunch and afterwards, a whole house tour of the Mansion.

This is a great opportunity to show support for the medical profession. Please join us.

Alliance Day at the Legislature

February 23 & 24, 1999

Alliance Day at the Legislature is an opportunity for physicians and their spouses to discuss issues with their elected officials. This day is well established at the Capitol and many legislators attend. *Spouses are not only welcome to join us both days – they are encouraged.*

Tuesday, February 23

Noon	Finance & Budget Committee Meeting (Sack Lunch)
2 p.m.	Deliver invitations to legislators
3:30 p.m.	Mid-Winter Board Meeting
6:30 p.m.	Cocktails/Dinner at Capitol Plaza Hotel MSMA lobbyist Tom Holloway will discuss current legislative issues

Wednesday, February 24

7:30 a.m.	Meet at the Capitol Building, lower level
8 a.m.	Legislators will begin to visit, coffee and rolls provided, you bring the conversation
10 a.m.	Observe sessions in the House and Senate or visit your legislator's office
11 a.m.	Tour of Cole County Historical Museum
Noon	Luncheon at Governor's Mansion/Whole House Tour

Alliance Day at the Legislature	**$25.00**
Governor's Mansion Luncheon	**$20.00**
Total Package Registration	**$45.00**

Register Soon!

Event deadline is February 10, 1999. ***Seating is limited to 60 for Governor's Mansion.***

Name ____________________

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List names of legislators you will personally invite: ____________________

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Complete form and send with appropriate fee payable to MSMAA to Eileen Chalk, 2108 Meadow Oaks Ln., Washington, MO 63090. Call Eileen at 314-390-2001 or fax registration to 314-239-0433.

Please note: A block of rooms has been reserved for MSMAA members. To make your hotel accomodations at the Capitol Plaza Hotel, call 573-635-1234 by February 10, 1999. After this date, rooms will be on sale to the public.

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Emergency Medicine Quiz

Mark T. Steele, MD
Chairman, Department of Emergency Medicine
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Virender Singhal, MD
Chief, Section of Plastic Surgery, Children's Mercy Hospital, Kansas City, Missouri

A 25-year-old male presents to the Emergency Department one and one-half weeks after having punched someone in the mouth. The patient complains of increasing hand pain and swelling. The patient's hand is depicted in Figure 1.

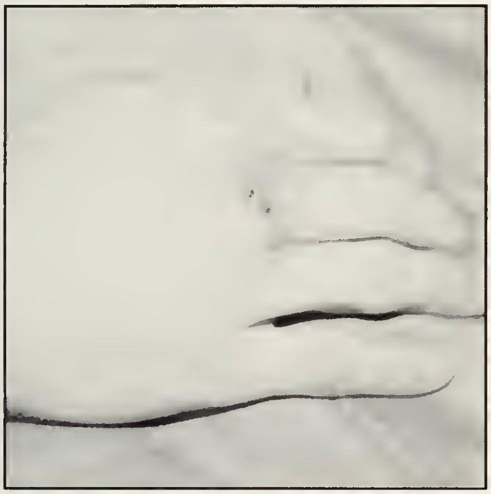

Figure 1

1. **Which of the following statements is true concerning human bites?**
   a. Bites in locations other than the hand do not have an unusually high rate of infection.
   b. Complications of clinched fist injuries include septic arthritis, tenosynovitis, and osteomyelitis.
   c. Infected wounds are polymicrobial with streptococci and staphlococci being the most common pathogens.
   d. Eikenella corrodens, a facultative anaerobic gram-negative rod, is found in about 15-25% of clinched fist infections.
   e. All of the above.

2. **Which of the following statments is false concerning clinched fist injuries of the hand?**
   a. Any laceration or puncture wound in the vicinity of the metacarpophalangeal joint should be considered a human bite until proven otherwise.
   b. X-rays should be obtained to rule out the presence of fractures, retained teeth or air in the joint.
   c. In the absence of infection, prophylactic antibiotics are not indicated.
   d. The hand should be splinted in a bulky dressing and tetanus immunizaiton provided if indicated.
   e. Hospital admission is indicated if signs of infection are present or there is evidence of joint, bone or tendon sheath involvement.

(See answers on next page.)

ANSWERS: 1: e. - All of the above
2: c. - Prophylactic antibiotics are indicated for all human bites of the hand.

There are two main varieties of human bites. The first type is the so-called clinched fist injury (CFI) or fight-bite which occurs when an individual strikes someone else in the mouth. These wounds are most commonly found over the dorsal ring or little digit metacarpophalangeal joints and are associated with a high incidence of infection. Infections are polymicrobial with streptococcus and staphylococcus being the most common aerobic pathogens. Gram-negative rods and anaerobes are also common, with Eikenella corrodens, a facultative anaerobic gram-negative rod being present in approximately 15-25% of CFI infections. Complications of these wounds include septic arthritis, tenosynovitis, and osteomyelitis. The patient described was admitted to the hospital and had a bone scan (Figure 2) obtained which demonstrated evidence of osteomyelitis/septic arthritis.

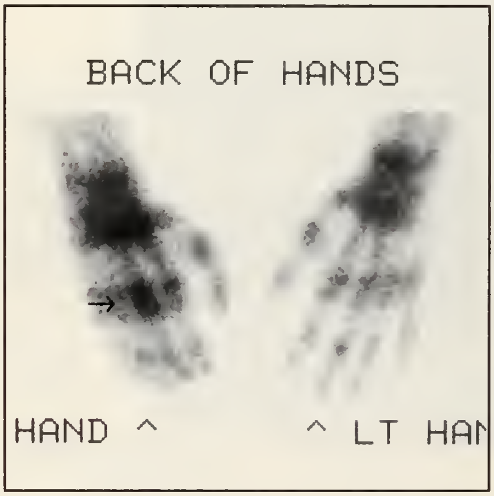

Figure 2

Because of the high incidence of infection and potential complications, any laceration or puncture in the vicinity of the metacarpophalangeal joints should be considered a CFI injury until proven otherwise. Wounds should be assessed for evidence of infection and a careful neurovascular exam should be performed. These wounds should be anesthetized and explored through a complete range of motion of the affected joint to look for evidence of tendon laceration, joint penetration or foreign bodies. Radiographs are recommended to rule out fractures, air in the joint or retained teeth. Because of the high incidence of infection, these wounds should be left open and the hand splinted with a bulky gauze dressing. Tetanus should be administered if indicated and prophylactic antibiotics administered.

Antibiotics that provide both aerobic and anaerobic coverage should be administered. Amoxicillin/clavulanate is the drug of choice for prophylaxis of uninfected CFI wounds. Patients with penicillin allergies should be treated with a combination of clindymicin and either ciprofloxicin or trimetheprim/sulfamethoxazole. Hospitalized infected wounds can be treated with ampicillin/sulbactam or cefoxitin. Ticarcillin/clavulanate or pippericillin-tazobactam are acceptable alternatives.

Healthy patients with no sign of infection or evidence of tendon, bone, or joint injury may be discharged with close follow-up in 1 to 2 days. Infected patients or patients with tendon, bone, or joint involvement should be hospitalized. Diabetics or immuno-suppressed patients with CFI injuries should also be hospitalized.

Human bites of the non CFI variety are common (i.e., neck, breast, arms, etc.) and are generally abrasive/contusive in nature. They are typically not full thickness wounds and have an infection rate that is no higher than ordinary lacerations. A study comparing this type of human bite with lacerations in an institutionalized population found no significant difference in infection between the two groups. These wounds are treated with irrigation and debridement like other types of lacerations. Prophylactic antibiotics are usually unnecessary unless the wound is full thickness or there is evidence of significant crush injury to the tissue.

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The HeartMate Left Ventricular Assist System: First Successful Implantation in Missouri

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Georgia E. Greer, MSN RN; Donald J. Voelker, MD; H.K. Reddy, MD;
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Abstract

We report a case of the first successful implantation of the HeartMate left ventricular assist system as a bridge to heart transplant in the state of Missouri. Indications, technique of insertion, patient selection, outcomes and future applications are discussed.

Introduction

End stage heart disease represents a major health problem in the United States today. Annually, an estimated 35,000 to 60,000 patients will develop congestive heart failure unresponsive to conventional medical management. Heart transplantation offers the best hope for many of these patients. Due to donor shortages, only approximately 2,400 patients per year undergo successful transplantation and a substantial number of patients die while waiting.[1]

Several ventricular assist devices have been developed to provide temporary mechanical circulatory support while waiting for transplantation. We report the first successful implantation of the HeartMate implantable pneumatic left ventricular assist system (LVAS) as a bridge to heart transplant in the state of Missouri.

Case Report

The patient was a 53-year-old former truck driver transferred to the University of Missouri Health Science Center with severe shortness of breath. He admitted to daily substernal chest pain, 2-pillow orthopnea, and paroxysmal nocturnal dyspnea. Over the previous two weeks he had worsening shortness of breath at rest with severe limitation in exercise tolerance.

The patient's past medical history was significant for a two-year history of worsening congestive heart failure, two previous myocardial infarctions, two previous angioplasty procedures, longstanding hypertension and non-insulin dependent diabetes mellitus. Medications included digoxin, furosemide, glyburide, and warfarin.

Physical examination showed a middle-aged man with ashen skin color in moderate respiratory distress. His height was 5' 11", weight 286 lbs., blood pressure 92/59, heart rate 112, respiratory rate 28. He exhibited jugular venous distension, decreased carotid upstroke, S_1, S_2, S_3, and S_4, with a I/VI systolic ejection murmur. He had 2+ pitting edema below the knees.

Laboratory analyses revealed normal electrolyte values, BUN 16 mg/dL, Cr. 1.2 mg/dL, glucose 111 mg/dL, hematocrit 34%, WBC 9,000/cu mm, PT 17.4 sec and PTT 29 sec. The chest roentgenogram was remarkable for cardiomegaly and pulmonary vascular congestion. Electrocardiogram showed sinus tachycardia, poor R wave progression, left anterior fascicular block, left atrial enlargement and nonspecific ST - T wave changes.

Intravenous dobutamine and milrinone and intra aortic balloon pump (IABP) counterpulsation were started. Catheterization confirmed moderate mitral insufficiency, diffuse non correctable coronary artery disease and an ejection fraction of 15%. Cardiac index was 1.82 L/min/m,[2] pulmonary vascular resistance 2.98 Wood units, central venous pressure 18 mmHg, pulmonary artery pressure 67/31 mmHg, pulmonary artery mean 47 mmHg, and pulmonary capillary wedge pressure 34 mmHg.

The patient was listed for cardiac transplantation as status I. Despite pharmacological and mechanical IABP support, the patient's condition did not improve. On hospital day five, he underwent placement of the HeartMate IP LVAS. A midline sternotomy incision was extended to the umbilicus and a preperitoneal pocket developed in the left upper quadrant of the abdomen. The patient was then placed on cardiopulmonary bypass. The inflow tube was brought through the diaphragm and positioned in the apex of the left ventricle. The blood pump was placed in the left upper quadrant, pneumatic drive line brought through the lower abdominal wall and the outflow graft sewn to the ascending aorta. With the device fully de-aired, the HeartMate was started in the automatic mode and pumping at 8 L/min. The patient was weaned from cardiopulmonary bypass and his chest and abdomen were closed. Figure 1 shows an x-ray with the device in place.

Nitric oxide at 30 ppm was used for the first 25 hours to control pulmonary vascular resistance and improve right heart function. He was extubated on postoperative day one, and transferred to intermediate care on postoperative day five. Over the next month the HeartMate functioned well with flow rates consistently between 7.0 - 9.0 L/minute. The patient began rehabilitation program walking on a treadmill up to 30 minutes per session with marked improvement in his stamina and strength. He was ambulating fully with the portable console.

Thirty-four days after placement of the assist device, the patient underwent explantation of the HeartMate and orthotopic cardiac transplantation. Pulmonary artery pressures at the time of transplantation had normalized. He did well and was discharged three weeks following his transplantation on triple drug immunosuppression.

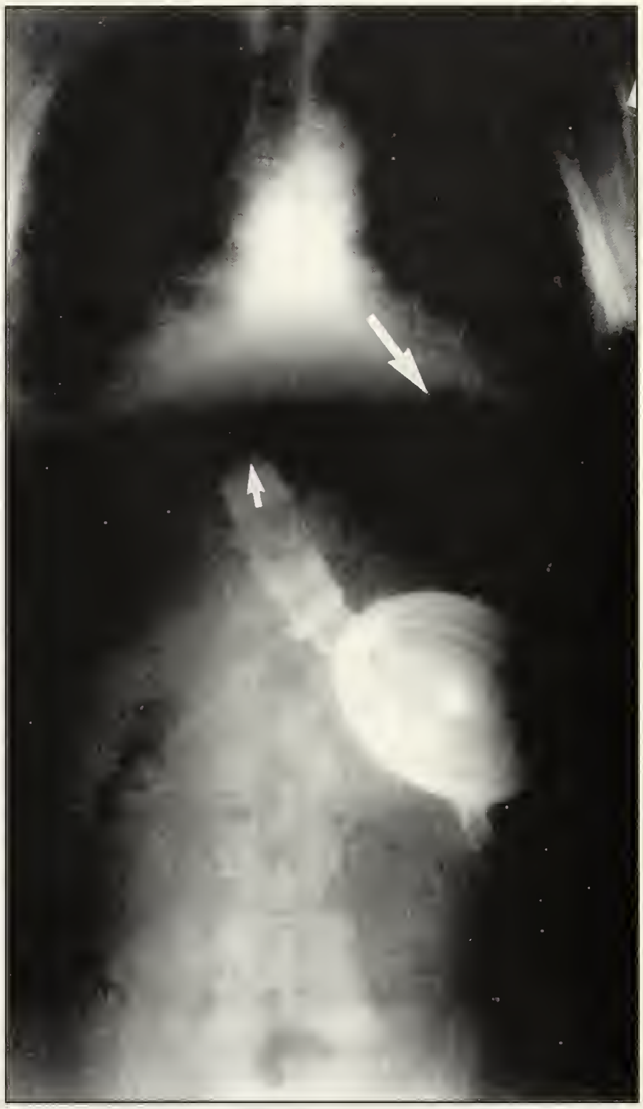

Figure 1. Chest x-ray showing position of the HeartMate IP LVAS. The inlet cannula (large arrow)connects to left ventricle draining blood to pump which ejects blood to ascending aorta by a connecting Dacron graft (small arrow).

Discussion

Device: The HeartMate IP LVAS (Thermo Cardiosystems Inc., Woburn, MA) is composed of an implantable blood pump, interconnecting drive line, and a portable external drive console. The blood pump provides left ventricular support and the console generates and controls pneumatic power through the interconnector driveline to the pump. The pump is 11.2 cm x 4 cm, weighs 570 gms and is composed of a rigid titanium housing divided into air and blood chambers by a flexible polyurethane diaphragm. The blood pump is placed in the left upper quadrant of the abdomen in either an intra-abdominal or preperitoneal location. The inlet tube of the pump is passed through the diaphragm and positioned in the left ventricular apex. Blood drains from the left ventricle into the pump and is ejected into the ascending aorta through a Dacron graft by displacement of the polyurethane diaphragm by pressurized air through a pusher-plate mechanism (Figure 2). Porcine valves within the inlet and outlet conduits ensure unidirectional flow. The pump has

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the capacity for an 83 ml stroke volume and potential flows up to 11 L/minute.

Textured surfaces within the blood pump provide an important advantage for this system. Sintered titanium microspheres and textured polyurethane allow development of a pseudoneointimal lining of the blood contacting surfaces. This "biologic" lining minimizes thromboembolic complications of the device and allows avoidance of anticoagulation.

The console contains a microprocessor which controls programmed pulses of air that drive the implanted pump. It can be run on alternating current continually or battery power for up to 40 minutes. Fully portable, the console weights 73 lbs. and is mounted on a cart with wheels, to allow the patient mobility.

Patient Selection: The HeartMate IP LVAS is fully approved by the Food and Drug Administration for temporary mechanical support of patients failing conventional treatment while waiting for heart transplantation. Current use is limited to approved transplant candidates who meet specific hemodynamic criteria. In contrast to extracorporeal left ventricular assist devices (LVADs) used for cardiogenic shock following cardiotomy or acute myocardial infarction, the HeartMate LVAS is used primarily for chronic cardiomyopathies as a bridge to transplant. Patients considered for LVAS placement usually have a PCWP ≥ 20 mmHg and a cardiac index ≤ 2.0 L/min/m^2 or a systolic blood pressure ≤ 80 mmHg.[2] The patients are usually failing on inotropes and often will have had an intraaortic balloon pump placed for stabilization.

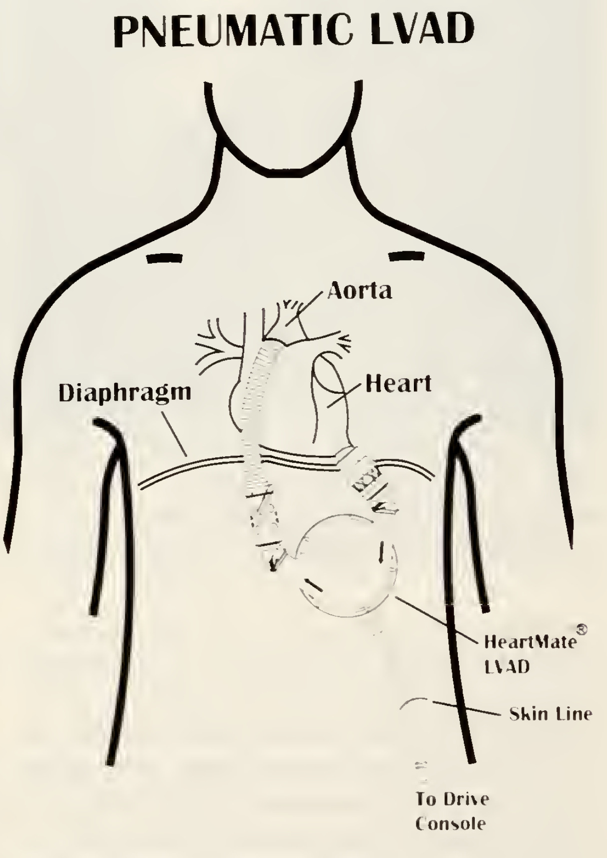

Figure 2. Diagram showing HeartMate IP LVAS and components. Blood drains from left ventricle into blood pump, pneumatic drive line connects console to pump, and outlet grafts connects to patient's aorta.

Exclusion criteria include chronic or irreversible hepatic, renal or respiratory failure, or severe aortic insufficiency. Bleeding problems and right heart dysfunction must be carefully evaluated prior to placement. Patients must have a BSA ≥ 1.5 m^2 due to the size of the device.

Rehabilitation: Once the HeartMate IP LVAS is placed, the patients are recovered in a manner similar to those undergoing conventional open heart surgery. Extubation takes place quickly once pulmonary artery pressures are normalized and the patient may require nitric oxide for the first 24 hours. Early ambulation and rehabilitation are important to improve the overall health of patients awaiting heart transplants. Patients participate in the rehabilitative process by walking on a treadmill or riding a stationary bicycle.

Outcomes: To date, 821 HeartMate implants have been performed throughout the United States. The longest period of implantation has been 726 days with an average duration of 81 days.

In a trial using concurrent controls involving 75 patients, the use of the HeartMate LVAS reduced mortality before and after transplantation. Patients receiving the device have a 71% vs. 36% survival until transplantation when compared to matched controls, and a 65% vs. 30% post transplant survival. Hemodynamics were markedly improved following placement of the HeartMate with average cardiac index rising from 1.86 to 2.77 L/min/m^2. Renal and hepatic indices returned to normal pretransplant and

NYHA functional classification went from class IV to class I in 91% of patients receiving the HeartMate.[3]

In summary, there is reduction in pretransplant mortality, improvement in health prior to transplant, reduction in perioperative transplant mortality and improved survival following transplant.

Future Applications: The HeartMate IP LVAS necessitates that the patient remain in the hospital while waiting for transplantation. A newer, totally electric device, the HeartMate Vented Electrical LVAS, may allow patients to leave the hospital while awaiting a donor heart. This device may also be used selectively for patients unsuitable for transplantation as a "destination."[4]

Summary

We present a 53-year-old man with end-stage cardiomyopathy and NYHA Class IV congestive heart failure failing conventional therapy with inotropes and an IABP. He recently underwent implantation of the HeartMate IP LVAS and was the first patient in Missouri to receive this therapy. He had the device implanted for one month, underwent rehabilitation, improvement in his pulmonary vascular resistance and subsequent successful cardiac transplantation. The indications, technique and results with the device are discussed. MoMed

The Authors

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MSMA Sponsored Annual Meetings and Events

Thursday, April 8

10:00-Noon	Opening Session, MSMA House of Delegates
1:30 pm	MSMA Reference Committees

Friday, April 9

9:00-10:30 am	MSMA General Session
11:00-1:00 pm	Medical Student Delegate Luncheon
Noon-2:00 pm	General Session
1:00-2:00 pm	MSMA Organized Medical Staff Section
4:00-6:00 pm	Second Session, MSMA House of Delegates

Saturday, April 10

8:00-Noon	MSMA Section on Young Physicians/International Medical Graduates General Session
1:00-2:00 pm	Open Forum on AMA Issues
6:30-7:30 pm	MSMA Presidential Inauguration
7:30-9:00 pm	MSMA Reception

Sunday, April 11

7:30 am	Final Session, MSMA House of Delegates Breakfast Meeting

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Annual Meetings and Events

Thursday, April 8

7:00-4:00 pm	**MSMA Registration**
7:00-9:30 am	Moneta Breakfast
7:00-9:30 am	MSMS, Inc. Breakfast
10:00-Noon	**Opening Session MSMA House of Delegates**
11:45-1:00 pm	St. Louis Metropolitan Medical Society Luncheon Caucus
Noon-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon Caucus
Noon-4:00 pm	MSMAA Registration
1:00 pm	MSMAA Past President's Luncheon
1:30 pm	**MSMA Reference Committees Meeting**
7:30 pm	MSMAA Dutch Treat Dinner

Friday, April 9

7:00-4:00 pm	**MSMA Registration**
7:00-8:30 am	Councilor Districts #1,2,5,6,8,9,10 Breakfast Meetings
7:30-9:00 am	University of Missouri-Columbia Alumni Organization Board of Governors Breakfast Meeting
8:00 am	MSMAA Past President's Breakfast
8:00-2:00 pm	MSMAA Registration
8:30-11:30 am	MSMAA General Assembly
9:00-10:30 am	**MSMA General Session**, "*Preserving The Physician-Patient Relationship*"
11:00-12:30 pm	Missouri Society of Otolaryngology - Head and Neck Surgery Scientific Presentation
11:00-1:00 pm	**Medical Student Delegate Luncheon**
Noon-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon
Noon-2:00 pm	**MSMA/Alliance General Session**, "*Domestic Violence*"
12:30-2:00 pm	University of Missouri-Columbia Alumni Luncheon
1:00-2:00 pm	Missouri Society of Otolaryngology-Head and Neck Surgery Scientific Presentation
1:00-2:00 pm	**MSMA Organized Medical Staff Section Business Session**
1:00-4:00 pm	Missouri Chapter, American Academy of Pediatrics Scientific Presentation
2:00-4:00 pm	St. Louis Metropolitan Medical Society Caucus
2:45-4:00 pm	Missouri State Medical Foundation Business Meeting
4:00-6:00 pm	**Second Session MSMA House of Delegates**
6:00-7:30 pm	University of Missouri-Kansas City, Washington University School of Medicine, University of Missouri-Columbia, St. Louis University School of Medicine Alumni Receptions
7:30-11:00pm	AMA Foundation Fundraiser

Annual Meetings and Events

Saturday, April 10

7:00-2:00 pm	MSMA Registration
7:00-8:00 am	Missouri Association of Plastic and Reconstructive Surgeons Breakfast Meeting
7:30-8:15 am	Missouri Society of Eye Physicians and Surgeons Breakfast Meeting
7:30-9:00 am	Missouri Society of Otolaryngology-Head and Neck Surgery Breakfast Business Meeting
7:45-9:45 am	Missouri State Neurological Association Scientific Presentation
8:00-10:00 am	MSMAA Registration
8:00-11:00 am	Missouri Academy of Family Physicians Scientific Presentation
8:00-11:30 am	Missouri Association of Plastic and Reconstructive Surgeons Scientific Presentation
8:00-Noon	**MSMA Young Physicians/International Medical Graduates General Session**, "*Contracting*"
8:30-11:30 am	MSMAA General Assembly
8:30-11:45 am	Missouri Society of Eye Physicians and Surgeons Scientific Presentation
9:15-Noon	Missouri Society of Otolaryngology-Head and Neck Surgery Scientific Presentation
11:00-Noon	**MMPAC Meeting**
Noon-2:00 pm	MSMAA Installation-Awards Luncheon
Noon-1:00 pm	Missouri Society of Otolaryngology-Head and Neck Surgery Luncheon
Noon-1:00 pm	Missouri Society of Eye Physicians and Surgeons Luncheon
Noon-1:00 pm	Missouri Association of Plastic and Reconstructive Surgeons Luncheon
1:00 pm	American College of International Physicians Scientific Presentation
1:00 pm	Missouri Association of Plastic and Reconstructive Surgeons Scientific Presentation
1:00-2:00 pm	**Open Forum on AMA Issues**
1:00-3:30 pm	Missouri Society of Eye Physicians and Surgeons Scientific Presentation
1:00-3:30 pm	Missouri Radiological Society Scientific Presentation
1:00-5:00 pm	Missouri Chapter, American College of Emergency Physicians Mini-Conference Presentation
2:00-4:00 pm	MSMAA Joint Convention Board Meeting
6:30-7:30 pm	**MSMA Presidential Inauguration**
7:30-9:00 pm	**MSMA/MSMAA Presidential Reception**

Sunday, April 11

7:30-9:00 am	**Final Session MSMA House of Delegates**

Annual Convention Deadlines . . .

January 22, 1999	Citizenship & Community Service Award Nominations
February 22, 1999	Resolutions for House of Delegates

The 1999 General Assembly: A Look Ahead

The 1999 General Assembly convenes on Wednesday, January 6, and will remain in session until May 14. If 1999 is like most other years, more than 1,300 bills will be introduced. Some 300 of those would impact the practice of medicine in one way or another.

At the time of this writing, no legislation, pending or planned, is available for scrutiny. But based on discussions with lawmakers, and a few red-hot rumors, MSMA's lobbying staff is willing to take a stab at clairvoyance. Following is their brief review of some of the legislation you might expect to see in 1999.

Medical Malpractice - Statute of Limitations

Last year legislation was proposed that would have allowed a medical malpractice action for failure to diagnose to be brought within two years of when the patient discovered or should have discovered the alleged malpractice. The current statute of limitations on malpractice claims is two years from occurrence (except for cases involving minors and foreign objects left in bodies). The proposed change would have had a dramatic impact on malpractice insurance rates and health care costs in general.

The bill was introduced in reaction to a case in St. Louis where a physician failed to notify a patient of an abnormal pap smear result. A worrisome level of support exists for extending the current statute of limitations on medical malpractice actions, and medicine could be in for the fight of its life. During the summer and autumn of last year, MSMA and several other key stakeholders negotiated with the plaintiff attorneys in an attempt to avoid political bloodshed. At the time of this writing the engaged parties were very near to striking a reasonable compromise. Watch the MSMA's *Legislative Report* for details.

Pharmacists' Scope of Practice

Missouri's pharmacists plan to propose legislation to allow them to prescribe drugs and modify a drug therapy in accordance with written guidelines or protocols provided by any practitioner authorized to prescribe drugs. Before a pharmacist would be allowed to provide these services, he or she would first have to complete an unspecified regimen of training (to be determined by the Board of Pharmacy). Of course, this proposal is fraught with problems. First and foremost, the retail pharmacy is not the appropriate setting in which to discuss and resolve medical problems. Moreover, prescribing and/or modifying a patient's drug therapy can only be done following an appropriate clinical assessment, and pharmacists simply are not trained to make these assessments. MSMA is stridently opposed to this measure.

Independent Practice for Physical Therapists

The physical therapists fought a well-organized battle last year for independent practice authority. They want to repeal the current law which prohibits PT's from practicing physical therapy independent of the prescription and direction of a physician, and from "treating or attempting to treat ailments or other health conditions of human beings other than by professional physical therapy." While PT's do provide very important health care services, they are not trained to make a complete patient evaluation or properly diagnose the many underlying disorders that cause musculoskeletal pain. MSMA fought hard to keep this bill subdued last year, and we will do so again in 1999.

Cancer Screening

Last year the General Assembly just missed passing a bill which would require insurers to cover annual pelvic exams and pap smears, prostate exams, and colorectal cancer exams. That coverage

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would be provided without deductibles, and would be subject to a co-payment not to exceed twenty-five dollars. The bill passed the House and had more than enough support for passage in the Senate, but died on the Senate Calendar when time ran out. While the cost of these cancer screens is relatively small – especially when compared to the costs of treating established cancer – some people cannot afford to pay for them and will go without. MSMA will support this legislation again in 1999.

Mastectomy Coverage

Last year MSMA almost succeeded in passing legislation that would have required insurers to cover at least 48 hours of inpatient care following a mastectomy and at least 72 hours following reconstructive surgery. The bill would have allowed the decision to keep the patient in the hospital to be made by the patient and the physician, not the insurance company. MSMA believes mastectomy is not an outpatient procedure, and we plan to revisit this issue this year.

Direct Access for OB/GYN Services

Legislation will be re-introduced to allow female HMO enrollees to seek the services of any participating obstetrician or gynecologist without a referral from a primary care provider (current law allows one visit per year to a participating OB-GYN without a referral). This issue had considerable support in both the House and Senate last year, but ran out of time before it could be passed into law. MSMA is opposed to any unreasonable restrictions on the patient's freedom to choose his or her own physician, including the right to seek direct access to specialists.

DWI - .08% BAC

MSMA and other safety advocates have worked for several years to lower Missouri's DWI threshold. In 1998, for the first time ever, committees in both the House and Senate approved legislation that would have reduced the legal blood-alcohol content from .10 to .08 percent.

The tragic consequences of mixing drinking and driving are well-documented. Alcohol-related traffic accidents exact a terrible cost that shouldn't be tolerated. Scientific studies clearly demonstrate impairment of judgement in individuals with blood alcohol levels as low as .04 percent. Setting the legal limit at .08 percent, and imposing stiff penalties for violating that limit, would be a giant step forward in the battle to rid the road of impaired drivers. We look forward to making another run at this issue in 1999.

Tobacco Settlement Money

The Missouri Attorney General recently signed a settlement agreement with the tobacco industry which will result in the state receiving $6.7 billion over the next twenty-five years. The agreement gives the General Assembly the authority to parcel out the funds, and there will be no shortage of ideas as to where the money should go. Should it fund the Medicaid program, or should it be used to support anti-smoking campaigns? Should it pay the costs of treating smoking-related diseases, or should it be doled out to local governments to discourage smoking in those jurisdictions? Already there is vigorous debate as to whether or not the Missouri Constitution – the so-called Hancock Amendment – requires the entire settlement to be returned to the taxpayers. This will be an interesting fight.

Seatbelts - Primary Enforcement

MSMA and other highway safety advocates plan to pursue legislation that would allow law enforcement officials to stop a vehicle for failure to obey seatbelt laws. Currently a vehicle must be stopped for some other offense before a citation can be issued for a seatbelt violation. Fourteen states now have primary enforcement laws. The seatbelt usage rate in those jurisdictions has climbed significantly, and the number of deaths and injuries – especially in children – has dropped commensurately. The Missouri General Assembly has tinkered with primary enforcement legislation in the past, but has yet to put any bill on the Governor's desk.

Small Business Insurance Plan

Representative Tim Harlan may revisit his plan to allow small businesses to buy into the Missouri Consolidated Health Care Plan (the plan for state and local government employees). His legislation to do just that very nearly passed into law in 1998.

During the fall Harlan chaired a special interim committee comprised of seven members of the House of Representatives which studied access to insurance by small businesses. At the time of this writing that committee had yet to make its conclusions known. Another special interim committee, this one comprised of seven members of the Senate, spent the fall investigating a recent spate of complaints about the Consolidated Health Care Plan. That committee's preliminary findings are that the Consolidated Plan should not be expanded until its operational problems are mitigated.

Certified Registered Nurse Anesthetists

Rumors abound that the CRNA's will pursue independent practice authority this year. At the time of this writing, no such legislation has been filed. But MSMA is preparing for battle. Evidently the CRNA's want to be allowed to administer anesthesia without the presence of a supervising physician. We think this is an irresponsible and extraordinarily dangerous proposition. The safe and efficacious administration of anesthesia requires the constant use of medical judgement, especially when life-threatening emergencies arise. Nurse anesthetists often are a valuable part of the anesthesia team, but their training and education does not render them capable of making critical medical assessments and decisions that could be the difference between life and death. Physician supervision is paramount, and MSMA will fight this proposal vigorously.

Registered Nurse First Assistants

Last year MSMA successfully blocked legislation that would have prohibited anyone other than a registered nurse first assistant or a surgical first assistant (which was defined as any physician, resident, intern, or physician assistant) to hold the title of "first assistant to a surgeon" during a surgical procedure. If this returns in 1999, we will fight it again.

Alcohol Tax

In 1998, Representative Mike Schilling authored an MSMA-supported bill which would have increased the tax on beer, wine, and spirits with proceeds earmarked exclusively for an alcohol abuse and dependency program administered by the Missouri Department of Mental Health. This so-called Penny-A-Drink bill would have levied little more than one cent per drink, but would have generated nearly $21 million to fight substance abuse. We hope to have the chance to pursue this again this year.

Three Surgery Limit

Twice last year, once on the Senate floor and once in a House committee, MSMA defeated an effort by a disgruntled Senator to make it unlawful for any physician "to perform more than three major surgeries in a single twenty-four hour period." If this reappears in 1999, we will smite it again.

Psychologist Prescriptive Authority

The psychologists are expected to renew their push for prescriptive authority in Missouri. Their 1998 legislation would have allowed them to prescribe drugs (including controlled substances) after completing two hundred hours of independent course study in pharmacology and one hundred hours of clinical training under the supervision of a physician. This legislation is part of a nationwide push by psychologists, and we expect to see it reappear this year. MSMA is strongly opposed to this proposal.

Child Abuse Reporting

MSMA and the Missouri Hospital Association conspired last year to defeat a bill that would have destroyed the immunity provided for physicians and other professionals who are mandated to report suspected child abuse. Current law holds the reporter immune from lawsuits unless he or she intentionally files a false report, or acts in bad faith or with ill intent. This bill would have held the reporter liable for damages if negligence was involved in making the report. Negligence is a terribly low standard, one that is relatively easy to prove in court. For instance, allegedly bad lighting in the examination room could be construed to be negligence. This would have crippled the child abuse reporting laws and probably would have resulted in very few cases being reported. If it shows up again this year, we'll work hard to kill it.

Radiologic Technologists

Last year MSMA succeeded in thwarting legislation that would have created a "Board of

Continued on page 22

Ionizing Radiation Technology" to issue certificates for general radiography, limited radiography, radiation therapy, and nuclear medicine technology. Under that bill, no person could use ionizing radiation on a human being unless he or she was first certified in one of the aforementioned categories. Physicians, medical students, dentists, chiropractors, podiatrists, and several other providers were exempt, but nurses were not. We expect to see this bill return in 1999, and we will fight it again.

Motorcycle Helmets

Every year for the last several years, MSMA and other safety advocates have managed (barely) to defeat an effort to repeal Missouri's motorcycle helmet law. The Freedom of the Road Riders and other cycling enthusiasts are proposing language that would allow any person twenty-one years of age or older to ride a motorcycle without protective headgear. MSMA considers this an important safety issue. Head injuries are devastating not only to the individual patient, but to the patient's family and the community as a whole. Unfortunately, this proposal has tremendous support in both the House and Senate, and it's just a matter of time before it becomes law.

Generic Substitution

The pharmacy lobby is expected to pursue legislation to allow pharmacists to make a generic substitution unless the prescriber, in his or her own hand, writes the words "Brand Medication Necessary" across the face of the prescription form. This issue has been around for several years and MSMA has strenuously opposed it.

Universal Health Care

Although support for a Canadian-style single-payer health care system has declined in Jefferson City, this bill's proponents always manage to put up a fight. Under their plan, all Missourians would be guaranteed free health care. There would be one payer – the state – and physicians would have to negotiate with the state on all fees for services. This issue almost certainly will be revisited in 1999, and MSMA will oppose it.

Workers' Compensation

Missouri's business community will make workers' compensation reform a high priority in 1999. Possible reforms being mentioned include Medicare's fee schedule for physicians' services and language that would allow the injured worker to choose a chiropractor for post-injury care. MSMA will monitor this effort very closely.

Marijuana

Legislation is introduced every year to legalize the use of marijuana – the plant itself – for medicinal purposes. MSMA supports carefully controlled scientific studies to evaluate marijuana's clinical efficacy, but does not, at this time, support adding it to the state's drug formulary. **MoMed**

Legislation and MSMA Policies Start With You

The ideas and needs of our members begin the process of creating legislation or policy supported by the Missouri State Medical Association. The first step is stating those needs in the form of a resolution. Resolutions may be submitted by individuals, component societies or groups of MSMA members.

For a resolution to be included in the MSMA 1999 Annual Meeting Delegate Handbook, (April 8-11, Tan-Tar-A Resort, Osage Beach, Mo.), it must be received at the MSMA office by February 22, 1999.

Mail your resolutions to: MSMA, 113 Madison Street, P.O. Box 1028, Jefferson City, MO 65102 or fax to: 573-636-8552.

Contacting Your Legislators

When considering various legislative proposals, lawmakers want to know the views of their constituents. They always are impressed when a physician takes time away from a busy schedule to call upon them.

No one knows more about health care than physicians. Legislators want to know your opinion, so tell them your thoughts.

You may want to visit your legislators in Jefferson City. Make an appointment to meet with them, or perhaps offer to take them to lunch or dinner.

Before you visit legislators, let MSMA lobbyists brief you on the status of legislation. Your visit will be more effective with complete knowledge of the status of particular bills.

A legislator's time is often limited, so let them know if you want to discuss a complicated subject matter that would take more time than a brief visit. Be sure to thank them for their time.

Stay in touch with your legislators. Let them know your interest is sincere and that they can contact you if they need more information on a medical issue. MoMed

Addressing a Public Official

Governor
The Honorable (full name)
Governor of Missouri
State Capitol Building
Jefferson City, MO 65101

Dear Governor (surname):

State Senator
The Honorable (full name)
Missouri State Senate
State Capitol Building
Jefferson City, MO 651010

Dear Senator (surname):

State Representative
The Honorable (full name)
House of Representatives
State Capitol Building
Jefferson City, MO 65101

Dear Representative (surname):

President of the United States
The President
The White House
Washington, D.C. 20500

Dear Mr. President:

U.S. Senator
The Honorable (full name)
U.S. Senate
Washington, D.C. 20510

Dear Senator (surname):

U.S. Representative
The Honorable (full name)
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative (surname):

Physician of the Day

Participate in MSMA's **Physician of the Day** Program and join the team of physicians who serve as the official physician on duty for lawmakers and staff in the Capitol. Call the MSMA office at 573/636-5151 for more information.

MSMA's Key Contact Program

Your action in MSMA's Key Contact Program is good, basic citizenship.

The members of the Missouri State Medical Association are all constituents represented by elected officials at the local, state, and federal levels of government. These legislators place great emphasis on what their most active constituents have to say, for it is these constituents who vote either to help re-elect them to another term of office or elect someone else to take their job.

When constituent involvement in the political process is applied on legislative issues, it is described as "grassroots" lobbying. Grassroots lobbying on legislative issues is critically important when MSMA wants to pass, amend, or defeat various proposals. To enhance its government relations effort through grassroots activity, MSMA has created the ***Key Contact Program***.

Activities in the ***Key Contact Program*** are based on two central premises. First, government actions have their greatest impact at the community level. As such, local constituent pressures can be exerted to help influence how a legislator votes.

Second, government actions and activities have become so important to the medical community that the responsibility for legislative effectiveness must in part reside with physicians - not just with your MSMA lobbyists. While its staff plays a fundamental role in the process, MSMA needs a broader base of political support to be more credible and effective.

Your action in MSMA's Key Contact Program is good, basic citizenship.

Traditionally, MSMA members have been called upon to write their lawmakers concerning government relations problems. However, our political needs now require participation that is more than just an occasional, informal effort. What is required is a systematic approach: MSMA's ***Key Contact Program***.

MSMA's ***Key Contact Program*** matches lawmakers with physicians from their districts who will keep in touch on legislative issues. That means each senator and representative will have at least one, and hopefully dozens of physicians in their district willing to take the time to call or write whenever medical issues arise. MSMA staff keeps its Key Contacts informed and engages the network when critical votes are expected or when certain lawmakers need to hear from a physician in their district.

The ***Key Contact Program*** is:

- strictly nonpartisan;
- information as well as action oriented;
- good, basic citizenship;
- taking an active role in the government process;
- getting to know your elected representatives;
- making your views known to your legislators.

MSMA's ***Key Contact Program*** promotes the interest of all physicians, their families, and patients with government officials. MoMed

If you are interested in becoming a Key Contact, please fill out the form on page 26 and return it to the MSMA.

Goals of the MSMA's Key Contact Program

- To promote the interests of your profession, your practice, and your patients through contacts with lawmakers;
- To better understand issues affecting medicine and be able to explain organized medicine's position to elected officials on a constituent basis;
- To inform other physicians of the impact of government legislation and regulation on their business and personal lives;
- To help legislators and other government officials understand the impact proposed legislation and regulations have on the health care delivery system;
- To motivate physicians, their patients, and their families to become involved in the political process.

Key Contact Responsibilities

Physicians serving as Key Contacts are asked to assume the following responsibilities in order to carry out the goals of the program:

- To represent the views of medicine to assigned federal and state elected officials in whose district you live;
- To develop personal, constituent relationships with your assigned elected officials and other government officials based on mutual respect and trust;
- To be aware of pending legislation at the state and federal levels and, with the assistance of MSMA staff, be prepared to discuss its impact on medicine, your patients, and the local community;
- To help build community understanding and support for MSMA's position on issues of major concern;
- To assist with the implementation of any future grassroots program activities that involve other physicians and other constituent support groups in the community.

Most of the people in this house have never practiced medicine.

Become a Key Contact for the 1998 Legislative Session!

Your Involvement is Key to our Success!

The Key Contact Program has been very successful. We hope you'll give it a try.
It takes no special training. We'll guide you along the way.
Just copy and fill out the form below and return it to:
MSMA, P.O. Box 1028, Jefferson City, MO 65102, Fax: 573-636-8552.

My state representative is: ______________________________

My state senator is: ______________________________

My name: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Make an Impact . . .
Support MMPAC!

Consider the dramatic changes proposed in Medicaid and Medicare.

Consider the relentless encroachment of managed care.

Consider proposed reforms in our medical malpractice laws.

Government has become an integral part of the practice of medicine. Virtually every medical decision you make will be impacted by health care policy decisions being made by lawmakers and bureaucrats.

The political arena is crowded with special interest groups and many of these groups do not have medicine's best interest in mind. As each interest speaks out on its own behalf, only a unified force made up of physicians and their spouses can best represent the medical community and the patient.

The Missouri Medical Political Action Committee – MMPAC – works on behalf of the entire medical profession, enabling us to speak as one powerful, amplified voice. The Association's bipartisan political action committee works with elected officials to make sure they understand every aspect of health care legislation.

MMPAC contributions support candidates who support the legislative goals of physicians. Candidates are selected based on recommendations from MMPAC members and local districts.

Your participation in MMPAC offers you an effective means to become involved in the political process and expand the influence of the medical community in the complex political world.

Your MMPAC contribution is an investment – in the medical profession, in the future of our health care system, and in the future of our many patients. MoMed

Please help us advance the high standards and practices of the medical profession.
Please make a contribution to MMPAC today.

$100 (regular membership)
$250 (SuperPac embership)

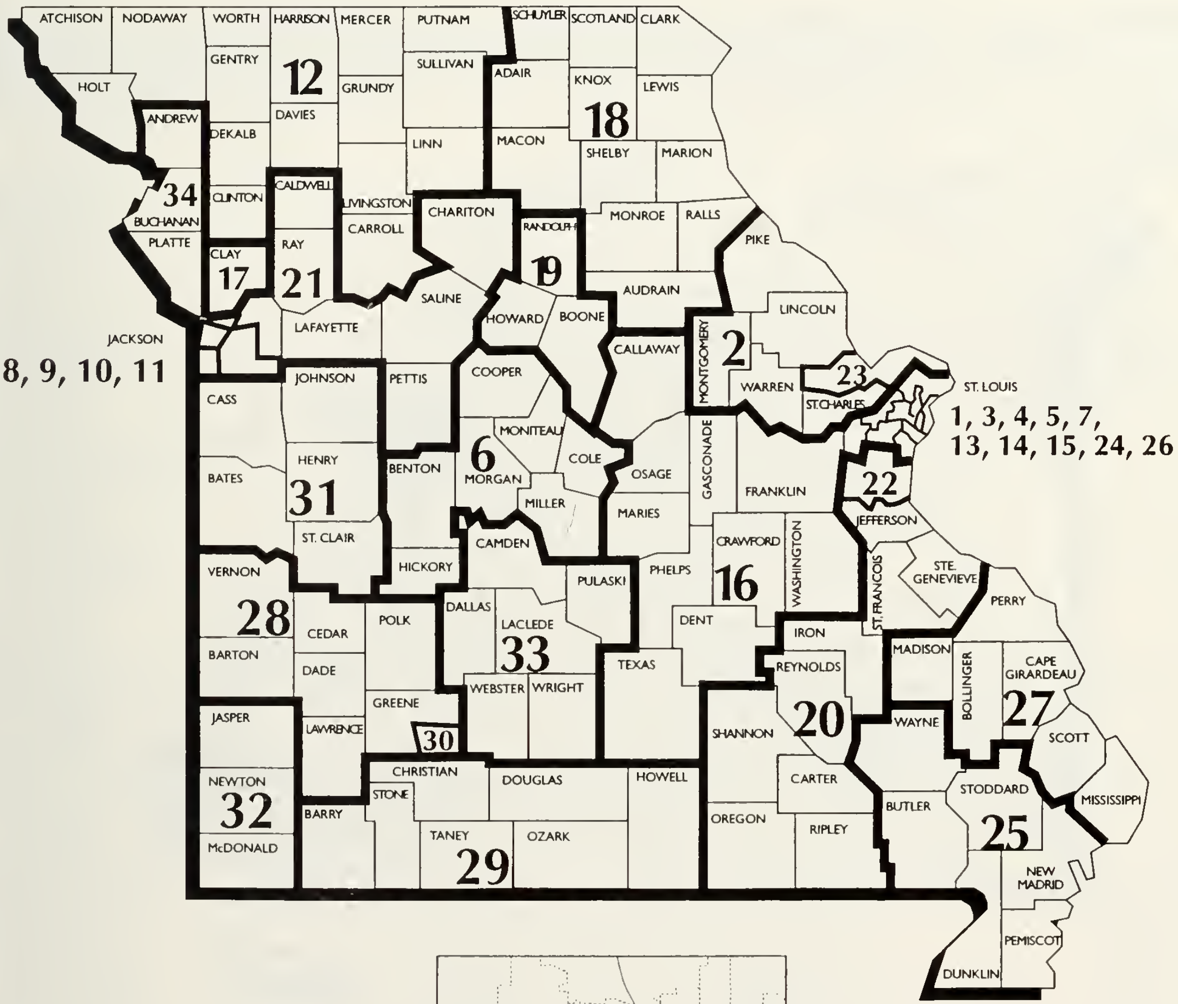
Send personal checks only, payable to:
MMPAC, P.O. Box 1402, Jefferson City, MO 65102

Every Member Benefits From MMPAC's Success!

Missouri Senate
90th General Assembly First Regular Session

SENATOR	DISTRICT	ADDRESS	PHONE	ROOM
Banks, J.B. (Jet)	5	1442A North Grand, St. Louis, MO 63106; 314/361-3800	**751-4650**	319
Bentley, Roseann	30	1500 E. Meadowmere, Springfield, MO 65804; 417/869-9933	**751-4145**	421
Caskey, Harold L.	31	P.O. Box 45, Butler, MO 64730; 660-679-4162	**751-4116**	320
Childers, Doyle	29	P.O. Box 127, Reeds Spring, MO 65737; 417/272-8281	**751-2058**	328
Clay Jr., William L.	4	6136 Washington Ave., St. Louis, MO 63112; 314/436-6699	**751-2229**	221
Bland, Mary	9	1632 Bushman, Kansas City, MO 64110; 816/233-4441	**751-2770**	334
DePasco, Ronnie	11	2917 Grand, Kansas City, MO 64108; 816/231-2515	**751-3074**	321
Ehlmann, Steve	23	415 N. Second St., St. Charles, MO 63301; 314/949-2323	**751-8635**	428A
Flotron, Francis E.	7	14 Arrowhead, Chesterfield, MO 63017; 314/434-2115	**751-2371**	331
Goode, Wayne	13	7231 Winchester Dr., St. Louis, MO 63121; 314/385-9010	**751-2420**	333
Graves, Sam	12	Rt. 2, Box 5, Tarkio, MO 64491; 660/736-5870	**751-3271**	225
House, Ted	2	3077 Winding River Dr., St. Charles, MO 63303; 314/447-3036	**751-8437**	227
Howard, J. T.	25	P.O. Box 279, Dexter, MO 63841; 573/624-8778	**751-3301**	331A
Jacob, Ken	19	4810 St. Charles Rd, Columbia, MO 65201; 573/442-2882	**751-2131**	420A
Johnson, Sidney	34	9970 Johnson Rd., Agency, MO 64401; 816/253-9248	**751-3750**	332
Kenney, Bill	8	2410 S.W. Hook Rd., Lee's Summit, MO 64082; 816/525-0605	**751-7050**	427
Kinder, Peter	27	635 N.W. End Blvd., Cape Girardeau, MO 63701; 573/335-6611	**751-2455**	431
Klarich, David	26	7700 Bonhomme, 7th Fl., Clayton, MO 63105; 314/727-0101	**751-1073**	434
Mathewson, James L.	21	1737 W. 10th, Sedalia, MO 65301; 660/826-7815	**751-4771**	323
Maxwell, Joe	18	210 E. Love, Mexico, MO 65265	**751-4200**	219
Mueller, Walt	15	12325 Manchester Rd., St. Louis, MO 63131; 314/966-2526	**751-3838**	330
Quick, Edward E.	17	13004 A. Highway, Liberty, MO 64068; 816/415-0199	**751-4524**	326
Rohrbach, Larry	6	HCR 60, Box 12, California, MO 65018; 573/796-3708	**751-2780**	433
Russell, John T.	33	P.O. Box 93, Lebanon, MO 65536; 417/532-6050	**751-4166**	419
Schneider, John D.	14	3520 Tremont Dr., Florrisant, MO 63033; 314/421-2762	**751-4106**	422
Scott, John E.	3	3761 Bates, St. Louis, MO 63116; 314/481-6864	**751-3644**	416
Sims, Betty	24	18 Ladue Manor, St. Louis, MO 63124; 314/432-8488	**751-7147**	226
Singleton, Marvin	32	114 W. 32nd St., Joplin, MO 64804; 417/781-2046	**751-2306**	426
Staples, Danny	20	HCR 3, Box 18, Eminence, MO 65466; 573/226-3386	**751-3534**	418
Steelman, Sarah	16	11916 Forest Lake Dr., Rolla, MO 65401	**751-4068**	425
Stoll, Stephen M.	22	716 Richard Ave., Festus, MO 63028; 314/931-1966	**751-1492**	429
Westfall, Morris	28	4671 Hwy. H, Halfway, MO 65663; 417/326-5156	**751-3645**	220
Wiggins, Harry	10	7817 Terrace, Kansas City, MO 64114; 816/444-5718	**751-2788**	423
Yeckel, Anita	1	8819 Gladlea, St. Louis, MO 63127; 314/729-0541	**751-2887**	329

Missouri Senate Districts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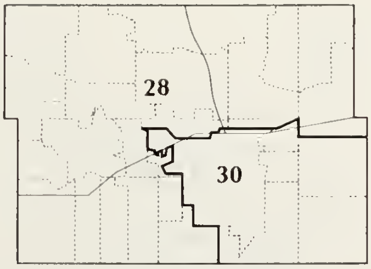
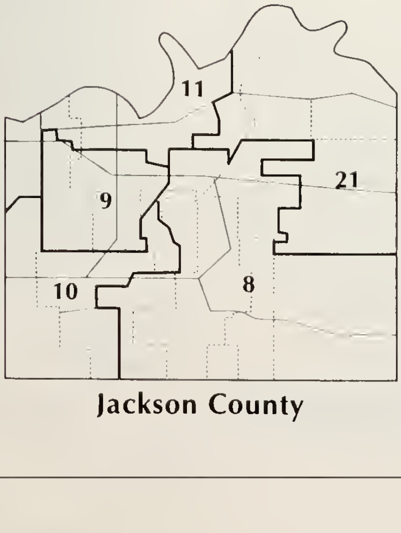
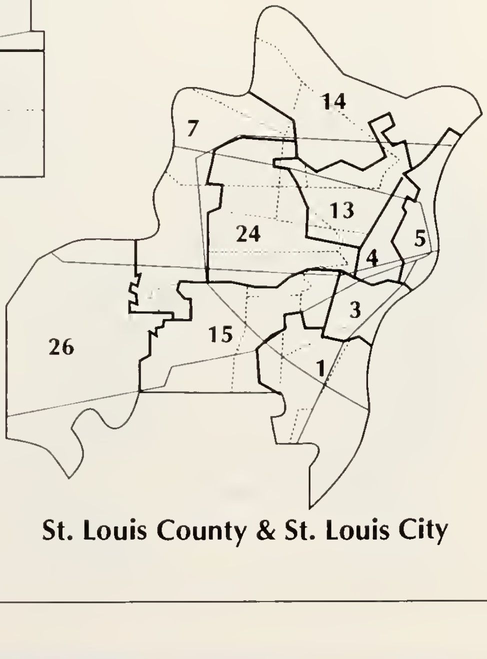


Greene County



Jackson County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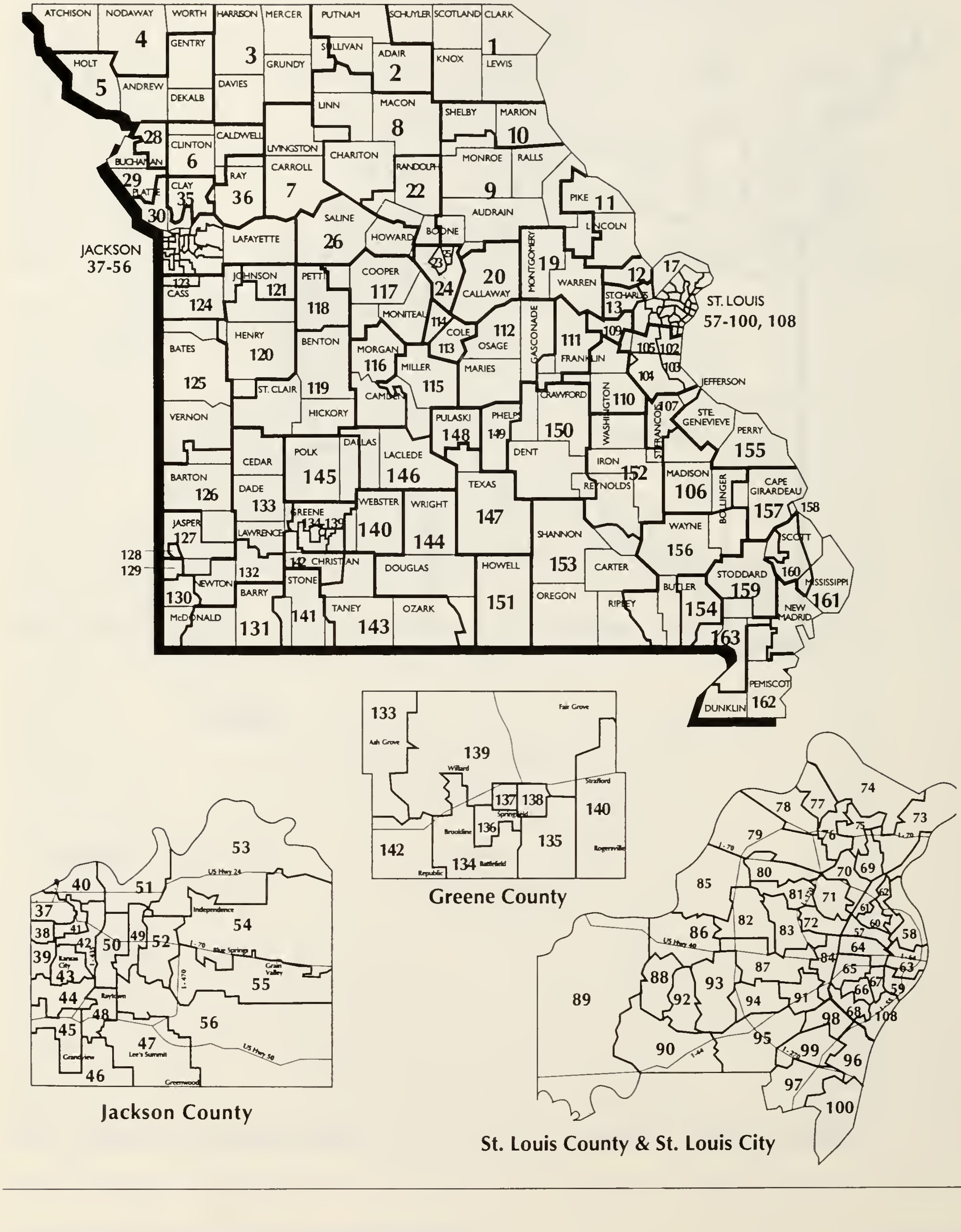
St. Louis County & St. Louis City

Missouri House Districts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Jackson County

Greene County

St. Louis County & St. Louis City

Missouri House of Representatives
90th General Assembly First Regular Session

*At the time of this printing, the House of Representatives had yet to finish making its office assignments final. In February, every MSMA member will receive MSMA's Legislative Directory with a complete listing of House and Senate member's office addresses and telephone numbers.

REPRESENTATIVE	DISTRICT	ADDRESS	PHONE	ROOM
Abel, Mark C.	**103**	928 Parkview, Festus, MO 63028		*
Akin, W. Todd	**86**	305 Conway Hill Rd., St. Louis, MO 63141; 314/434-7948	**751-1186**	
Alter, Bill	**90**	1800 Gravois, High Ridge, MO 63049; 314/677-8191	**751-2732**	
Auer, Ron	**59**	3120 S. Compton, St. Louis, MO 63118; 314/453-1894	**751-4567**	
Backer, Gracia Y.	**20**	2859 Rt. TT, New Bloomfield, MO 65063; 573/295-6190	**751-2070**	
Ballard, Charles	**140**	Rt. 4, Box 3450, Marshfield, MO 65706; 417/859-6454	**751-9809**	
Barnett, Rex	**4**	708 West Lincoln, Maryville, MO 64468; 816/582-4014	**751-9465**	
Barry, Joan	**100**	5050 Lampglow Ct., St. Louis, MO 63129; 314/487-1558	**751-9804**	
Bartelsmeyer, Linda	**132**	1668 Oak Drive, Aurora, MO 65605; 417/678-5822	**751-9806**	
Bartle, Matt	**56**	1600 N.E. Jade St., Lee's Summit, MO 64086		
Bennett, Jon	**15**	1268 Heritage Court, St. Charles, MO 63303; 314/440-2300	**751-9627**	
Berkowitz, Sam	**1**	R.R. #3, Box 65, Memphis, MO 63555		
Berkstresser, Judy	**141**	RR#1 Box 349B, Crane, MO 65633; 417/723-8864	**751-1503**	
Black, Lanie	**161**	671 N. 407th Rd., Charleston, MO 63834		
Blunt, Matt	**139**	3711 N. Rogers Ave., Springfield, MO 65803		
Boatright, Matt	**118**	29612 Pony Path Rd., Sedalia, MO 65301; 816/826-1880	**751-9774**	
Bonner, Dennis	**51**	947 S. Washington, Independence, MO 64050; 816/842-0707	**751-5701**	
Boucher, Bill	**48**	11320 Sunnyslope Dr., Kansas City, MO 64134; 816/966-8576	**751-7335**	
Boykins, Amber (Holly)	**60**	4815 Lee Ave., St. Louis, MO 63115		
Bray, Joan	**84**	7120 Washington Ave., St. Louis, MO 63130; 314/725-7862	**751-2514**	
Britt, Phillip	**163**	120 Bradford Pl., Kennett, MO 63857		
Burton, Gary L.	**128**	801 Fir Rd., Joplin, MO 64836; 417/623-6400	**751-7082**	
Campbell, Marsha	**39**	445 Westover Rd., Kansas City, MO 64113; 816/363-8474	**751-4485**	
Carter, Paula J.	**61**	5936 Summit, St. Louis, MO 63147; 314/382-2900	**751-6500**	
Champion, Norma	**134**	3609 S. Broadway, Springfield, MO 65807; 417/865-2815	**751-2583**	
Chrismer, Rich	**16**	25 Barkwood Trails, St. Peters, MO 63376; 314/441-6219	**751-2949**	
Cierpiot, Connie J.	**52**	15403 E. 44th, Independence, MO 64055; 816/373-8935	**751-9759**	
Clayton, Robert	**10**	2827 Pleasant St., Hannibal, MO 63401; 573/221-7333	**751-9614**	
Cooper, Bonnie Sue	**32**	413 NW 58th St., Kansas City, MO 64118; 816/453-4419	**751-2134**	
Crawford, Larry	**117**	RR#2, Box 95, Centertown, MO 65023; 573/796-2071	**751-2134**	
Crump, Wayne F.	**152**	606 Pine St., Potosi, MO 63664; 573/751-2101	**751-2101**	
Daniel, Lloyd	**42**	4437 Benton Blvd., Kansas City, MO 64130; 816/292-2835	**751-9758**	
Daniels, Fletcher	**41**	3537 Askew, Kansas City, MO 64128; 816/924-1513	**751-3158**	
Davis, D. J.	**122**	204 N. Connor, Odessa, MO 64076; 816/230-5224	**751-1500**	
Davis, Dorathea	**63**	3305 Lemp, St. Louis, MO 63104; 314/773-4770	**751-2606**	
Days, Rita D.	**71**	3083 Bellerive Dr., St. Louis, MO 63121; 314/385-0447	**751-4468**	
Dolan, Jon	**13**	902 Bridlespur Ln., Lake St. Louis, MO 63367; 314/947-1515	**751-4964**	
Dougherty, Patrick	**67**	4031 Parker Ave., St. Louis, MO 63116; 314/772-1948	**751-3599**	
Elliott, T. Mark	**127**	208 Fairway, Carl Junction, MO 64834; 417/673-8464	**751-5458**	
Enz, Catherine S.	**99**	10018 St. Simon Ct., St. Louis, MO 63123; 314/435-0220	**751-9768**	
Evans, Brent	**92**	4 Westbrooke Terr. Ct., Manchester, MO 63021; 314/878-7887	**751-9765**	
Farnen, Ted	**21**	13 Wonneman Circle, Mexico, MO 65265; 573-581-1000	**751-9458**	
Fitzwater, Rodger	**36**	RR#2, Box 206, Norborne, MO 64668; 816/484-3500	**751-9757**	
Foley, James Michael	**81**	3274 Adie Rd., St. Ann, MO 63074; 314/426-7675	**751-0855**	
Ford, Louis H.	**58**	3229 North 20th St., St. Louis, MO 63107; 314/241-1626	**751-2383**	
Foster, Bill I.	**156**	RR#9, Box 252-1, Poplar Bluff, MO 63901; 573/785-3586	**751-3859**	

Franklin, Richard	**53**	18005 Cheyenne, Independence, MO 64056; 816/796-3088	**751-6535**
Fraser, Barbara	**83**	581 Stratford Ave., St. Louis, MO 63130	
Froelker, James V.	**111**	7437 Highway H, Gerald, MO 63037; 573/925-4142	**751-6668**
Gambaro, Derio	**65**	5320 Wilson, St. Louis, MO 63110	
Gaskill, Sam	**131**	HCR 79, Box 345, Washburn, MO 65772; 417/435-2304	**751-9801**
Gaw, Steve	**22**	P.O. Box 314, Moberly, MO 65270; 816/263-9000	**751-2700**
George, Tom	**74**	3594 Monsols Dr., Florissant, MO 63034	
Gibbons, Michael R.	**94**	651 Pearl Ave., Kirkwood, MO 63122; 314/821-4616	**751-2853**
Graham, Chuck	**24**	102 W. Green Meadows, Columbia, MO 65203; 573/442-0427	**751-2162**
Graham, Jim	**106**	Rt. 1, Box 145, Fredericktown, MO 63645; 573/783-7707	**751-3455**
Gratz, William (Bill)	**113**	2315 Rt. M, Jefferson City, MO 65101; 573/635-4168	**751-0665**
Green, Timothy P.	**73**	617 Science Hill, St. Louis, MO 63137; 314/869-9376	**751-6845**
Griesheimer, John E.	**109**	33 Oxford Dr., Washington, MO 63090; 314/583-8000	**751-3678**
Gross, Charles	**18**	3019 Westborough Ct., St. Charles, MO 63301; 314/947-7893	**751-1141**
Gunn, Russell	**70**	6723 Maryellen, Northwoods, MO 63121; 314/382-1331	**751-4726**
Hagan-Harrell, Mary	**75**	100 Florwood Ct., Ferguson, MO 63135; 314/521-5555	**751-5836**
Hampton, Mark	**147**	HC 67, P.O. Box 108, Summersville, MO 65571	
Hanaway, Catherine	**87**	1349 N. Berry Rd., St. Louis, MO 63122	
Harlan, Tim	**23**	511 S. Glenwood Ave., Columbia, MO 65203; 573/874-2402	**751-9753**
Hartzler, Ed	**123**	303 Manor Ct., Belton, MO 64012; 816/331-0090	**751-2175**
Hartzler, Vicky	**124**	22804 E. 299th St., Harrisonville, MO 64701; 816/884-5297	**751-9780**
Hegeman, Daniel J.	**5**	18739 County Rd. 294, Cosby, MO 64436; 816/662-2645	**751-0246**
Hendrickson, Carl	**97**	4661 Markton Dr., St. Louis, MO 63128; 314/554-3183	**751-9766**
Hickey, John	**80**	11743 Laux, Bridgeton, MO 63044; 314/298-8370	**751-4670**
Hilgemann, Robert	**64**	4131 Blaine Ave., St. Louis, MO 63110; 314/771-4718	
Hohulin, Martin (Bubs)	**126**	360 N.W. 20th Rd., Lamar, MO 64759; 800/878-7126	**751-2165**
Holand, Roy	**135**	1840 E. Vincent, Springfield, MO 65804; 417/885-7110	**751-2210**
Katherine Hollingsworth	**101**	1129 Westward Trails, Imperial, MO 63052; 314/342-4455	**751-1311**
Hoppe, Thomas	**46**	12316 Charlotte, Kansas City, MO 64146; 816/561-2067	**751-9469**
Hosmer, Craig	**138**	657 S. Weller, Springfield, MO 65802; 417/869-0581	**751-9474**
Howerton, Jim	**120**	535 N.W. 1250, Chilhowee, MO 64733; 816/678-3331	**751-1484**
Kasten, Mary C.	**158**	1209 Sailor Circle, Cape Girardeau, MO 63701; 573/334-3111	**751-2459**
Kelley, Pat	**47**	3924 SW Windsong Dr., Lee's Summit, MO 64082; 816/254-5116	**751-1456**
Kelly, Glenda	**27**	3415 N. 3rd St., St. Joseph, MO 64505; 816/233-2614	**751-9755**
Kennedy, Harry	**66**	4959 Sutherland, St. Lous, MO 63109; 314/481-5857	**751-2126**
King, Jerry	**125**	Rt. #4, Box 416, Butler, MO 64730	
Kissell, Don	**17**	408 Sutters Mill, St. Peters, MO 63376; 314/990-9099	**751-9628**
Klindt, David	**3**	32559 E. 280th Ave., Bethany, MO 64424; 660/425-6876	**751-1415**
Koller, Don	**153**	P.O. Box 135, Summersville, MO 65571; 417/932-4064	**751-2112**
Kreider, Jim	**142**	P.O. Box 1980, Nixa, MO 65714; 417/443-3006	**751-2956**
Lakin, Scott	**33**	3700 NE 49th Terr, Kansas City, MO 64119; 913/338-2525	**751-6600**
Lawson, Maurice	**29**	4105 Christy Ln., St. Joseph, MO 64504; 816/271-1454	**751-9460**
Leake, Sam	**9**	RR#2, Box 61A, Laddonia, MO 63352; 573/373-5685	**751-7852**
Legan, Kenneth	**145**	1901 E. 487th Rd., Halfway, MO 65663; 417/445-2241	**751-3819**
Levin, David	**82**	11208 Sherwood Oak Ct., St. Louis, MO 63146; 314/432-6502	**751-9762**
Liese, Chris	**85**	1948A Marine Terr. Dr., St. Louis, MO 63146; 314/878-4787	**751-1832**
Linton, William C.	**89**	17339 Cougar Trail, Grover, MO 63040; 314/458-0736	**751-1247**
Lograsso, Don	**54**	404 Stonewall Dr., Blue Springs, MO 64014; 816/228-7551	**751-1487**
Long, Elizabeth L.	**146**	22975 Oneida Dr., Lebanon, MO 65536; 417/532-6946	**751-4451**
Loudon, John	**88**	221 Pleasant Grove Ln., Ballwin, MO 63011; 314/623-6012	**751-9763**
Luetkemeyer, Blaine	**115**	Hwy. 52 East, St. Elizabeth, MO 65075	
Luetkenhaus, Bill	**12**	742 Hancock Rd., Wentzville, MO 63385; 314/327-6539	**751-2176**
Marble, Gary	**130**	12083 Mallard Dr., Neosho, MO 64850; 417/451-1455	**751-9781**
May, Brian H.	**108**	5816 Pennsylvania, St. Louis, MO 63111; 314/621-4500	**751-0438**
Mays, Carol Jean	**50**	3603 Hedges, Independence, MO 64052; 816/252-0900	**751-7639**
McBride, Jerry E.	**149**	P.O. Box 292, Edgar Springs, MO 65462; 573/435-6639	**751-4950**
McClelland, Emmy L.	**91**	455 Pasadena, Webster Groves, MO 63119; 314/962-1796	**751-1285**
McKenna, Ryan	**102**	6969 Dippel Ln., Barnhart, MO 63012	
McLuckie, Steve	**44**	9738 Shepards Dr., Kansas City, MO 64131; 816/756-1818	**751-2437**

Merideth III, Denny J.	**162**	Route 1, Box 259, Caruthersville, MO 63830	**751-2264**
Miller, Ronnie	**133**	623 Morgan Dr., P.O. Box 5, Stockton, MO 65785; 417/226-3343	**751-1347**
Monaco, Ralph	**49**	7013 Englewood, Raytown, MO 64133; 816/333-9600	**751-9851**
Murphy, Jim	**95**	9314 Cordoba Ln., Crestwood, MO 63126; 314/849-5914	**751-2150**
Murray, Dana L.	**69**	2422 Mary, St. Louis, MO 63136; 314/388-0417	**751-5538**
Myers, Peter	**160**	519 Tanglewood, Sikeston, MO 63801	
Naeger, Patrick A.	**155**	14 Richardet, Perryville, MO 63775; 573/547-4526	**751-9812**
Nordwald, Charles	**19**	#20 Hawthorne, Warrenton, MO 63383; 314/338-4404	**751-2689**
O'Connor, Patrick	**79**	4413 Claremont, Bridgeton, MO 63044; 314/298-7418	**751-2726**
O'Toole, James P.	**68**	5445 Finkman, St. Louis, MO 63109; 314/353-0864	**751-2251**
Ostmann, Cindy	**14**	445 Knaust Rd., St. Peters, MO 63376; 314/240-5376	**751-2250**
Overschmidt, Francis S.	**110**	151 N. Outer Rd., Union, MO 63084; 314/583-5591	**751-2398**
Parker, Kelly	**150**	#3 Amber Trail, Salem, MO 65560; 573/729-3127	**751-2108**
Patek, Jewell	**7**	P.O. Box 55, Chillicothe, MO 64601; 816/752-7745	**751-2917**
Pouche, Fred	**30**	10015 N.W. Mirror Lake Dr., Kansas City, MO 64152; 816/741-6537	**751-9756**
Pryor, Charles R.	**116**	410 W. Newton, Versailles, MO 65084; 573/378-4082	**751-4119**
Purgason, Chuck	**151**	2680 Rd. 7360, Caulfield, MO 65626; 417/284-3332	**751-1882**
Ransdall, Bill	**148**	503 Wildwood Ln., Waynesville, MO 65583; 573/341-3838	**751-1727**
Reid, Michael J.	**78**	759 Carriage Ln., Hazelwood, MO 63042	
Reinhart, Annie	**34**	617 Lancelot, Liberty, MO 64068; 816/781-2919	**751-1218**
Relford, Randall	**6**	504 Country Club Square, Cameron, MO 64429; 816/632-7414	**751-9819**
Reynolds, David L.	**77**	1325 Verlene Dr., Florissant, MO 63031; 314/839-1111	**751-9761**
Richardson, Mark L.	**154**	3411 Normandy Rd., Poplar Bluff, MO 63901; 573/686-3342	**751-4039**
Ridgeway, Luann	**35**	19405 Platte Co. Line Rd., Smithville, MO 64089; 816/532-0032	**751-2238**
Rizzo, Henry C.	**40**	575 Harrison, Kansas City, MO 64106; 816/833-4700	**751-3310**
Robirds, Estel	**143**	Rt. 2, Box 2919, Theodosia, MO 65761; 417/273-4777	**751-2042**
Ross, Carson	**55**	3305 Park Ln., Blue Springs, MO 64015; 816/274-4435	**751-8636**
Sallee, Mary Lou	**144**	914 N.W. 9th St., Ava, MO 65608; 417/683-4286	**751-2205**
Scheve, May	**98**	6612 Gramond, St. Louis, MO 63123; 314/849-3704	**751-9472**
Schilling, Mike	**136**	1027 S. New, Springfield, MO 65807; 417/862-2272	**751-2652**
Schwab, David	**157**	2835 County Road 435, Jackson, MO 63755; 573243-5966	**751-6662**
Scott, Delbert	**119**	P.O. Box 147, 700 E. 7th, Lowry City, MO 64763; 417/644-2244	**751-8793**
Secrest, Patricia K.	**93**	723 Country Heights Ct., Manchester, MO 63021; 314/821-2040	**751-4392**
Seigfried, James	**26**	1560 The Oaks, Marshall, MO 65340; 816/886/6957	**751-2204**
Selby, Harold R.	**105**	5548 Twilight, Cedar Hill, MO 63016	
Shelton, O.L.	**57**	1803A Cora, St. Louis, MO 63113; 314/533-1322	**751-2198**
Shields, Charles W.	**28**	47 S.E. Erin Ct., St. Joseph, MO 64507; 816/233-8090	**751-9476**
Skaggs, Bill	**31**	3613 North Park, Kansas City, MO 64116; 816/452-5328	**751-2199**
Smith, Philip	**11**	215 N. Third, Louisiana, MO 63353; 573/754-4577	**751-9459**
Stokan, Lana	**76**	1589 Knollway Dr., Florrissant, MO 63135; 314/838-6497	**751-9760**
Summers, Don	**2**	Rt. 4, Box 209, Unionville, MO 63565; 816/947-2283	**751-0224**
Surface, Chuck	**129**	2401 W. 29th, Joplin, MO 64804; 417/624-5695	**751-2173**
Thompson, Betty	**72**	8315 Seville, University City, MO 63132	
Thompson, Vernon	**37**	1330 Park, Kansas City, MO 64127; 816/474-1151	**751-1309**
Townley, Merrill	**112**	RR#1, Chamois, MO 65024; 314/763-5795	**751-1344**
Treadway, Joseph L.	**96**	1456 Telegraph, Lemay, MO 63125; 314/878-4200	**751-2315**
Troupe, Charles Quincy	**62**	5338 Claxton, St. Louis, MO 63120; 314/383-3814	**751-2851**
Tudor, Bill	**45**	12528 Askew Dr., Grandview, MO 64030	
Van Zandt, Tim	**38**	4637 Charlotte, Kansas City, MO 64110; 493/931-9462	**751-5282**
Vogel, Carl	**114**	311 Constitution, Jefferson City, MO 65109; 573/636-6165	**751-2076**
Wagner, Wes	**104**	3099 Oakvale Rd., DeSoto, MO 63020	
Ward, Dan	**107**	412 Young St., Bonne Terre, MO 63628	
Wiggins, Gary	**8**	30093 St. Hwy. P, New Cambria, MO 63558; 816/226-5619	**751-1042**
Williams, Deleta	**121**	713 Tyler, Warrensburg, MO 64093; 816/429-6893	**751-2272**
Williams, Marilyn A.	**159**	108663 County Rd. 442, Dudley, MO 63936; 573/624-8333	**751-0728**
Wilson, Vicky	**25**	3201 Blackberry Ln., Columbia, MO 65201; 573/882-5859	**751-1169**
Wright, Mark	**137**	1890 N. Grant, Springfield, MO 65803	

Membership Notes

In The News

Senator Marvin Singleton, MD, R-Seneca, was recently reappointed as Clinical Assistant Professor at the University of Missouri-Columbia Division of Otolaryngology and the Department of Surgery.

Dennis Choi, MD, PhD, a neuroscientist at Washington University School of Medicine in St. Louis received the 1998 Christopher Reeve Research Medal at the American Paralysis Association Gala in New York City. The medal is named for actor Christopher Reeve, who presented it to Dr. Choi with a $50,000 prize.

Gordon Bloomberg, MD, professor of pediatrics at the Washington University School of Medicine in St. Louis, received a $15,000 grant from The American Academy of Allergy, Asthma, and Immunology for a research project titled "The Role of Family Disorganization in Repeated Hospitalization for Children."

In Memoriam

William G. Arney, MD, St. Louis, died November 11, 1998. Dr. Arney was a psychiatrist and a member of the Missouri State Medical Association.

Anita C. Younger, MD, Overland Park, KS, died November 19, 1998. Dr. Younger was a family practitioner and a member of the Missouri State Medical Association

D. Elliott O'Reilly, MD, St. Louis, died November 20, 1998. Dr. O'Reilly was an orthopedic surgeon and a member of the Missouri State Medical Association.

Wallace R. Stacey, MD, Independence, died November 20, 1998. Dr. Stacey was an obsetrician/gynecologist and a member of the Missouri State Medical Association.

Classified Advertising

Rural Locum Tenens

FP with OB BC/FP **physician available** for a short term practice coverage. Liability insurance provided. Please contact: **V. Braslavsky, MD, 913-383-3285, http://www.concentric. net/~locumdr/1.htm**

Family Physician Seeks Group Practice

Experience Family Physician (MD) seeks association with a Family Practice group in the Kansas City area. Kansas and Missouri licensed with current participation in numerous insurance plans (i.e. BC & BS, Healthnet, Aetna, Boyd's Gaming, Perr's, Principal, Truman Health Plan, etc.).

Contact: S.A. Brooks
2813 W. 51st
Westwood, KS 66205
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Harrisonville, Missouri: Best of both worlds: rural, small-group atmosphere, urban, large-group amenities. Seeking quality, primary care or emergency medicine trained physicians for 10,000 annual volume Emergency Medicine practice. Full and regular part-time opportunities. 12-hour shifts.

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Missouri Physicians Health Program

1-800-274-0933

Help for physicians.

CME Listing

FEBRUARY

8 - *St. Louis:* **Title TBA.** Call Mallinckrodt 314-362-7130.

27 - *St. Louis:* **The Spine: Skull to Sacrum/Birth to Old Age - for Primary Care Physicians.** Call Washington University 314-362-6287.

MARCH

8 - *St. Louis:* **State-of-the-Art Clinical Applications of Cardiovascular Nuclear Medicine: Diagnosis, Prognosis, and Myocardial Viability.** Call Mallinckrodt 314-362-7130.

12 & 13 - *St. Louis:* **Coagulation Consultants Annual Symposium.** Call St. Louis University 800-553-2712.

11 thru 13 - *St. Louis:* **7th Annual Refresher Course & Update in General Surgery.** Call Washington University 314-362-6287.

19 thru 21 - *St. Louis:* **Neurosurgical Approaches to the Carotid Artery.** Call St. Louis University 314-577-8167.

20 & 21 - *St. Louis:* **Neurosurgical Approaches to the Carotid Artery.** 14 credit hours. Call Sandy Turck 314-535-4000.

27 - *St. Louis:* **Hepatobiliary Disease.** Call St. Louis University 800-553-2712.

APRIL

12 - *St. Louis:* **Leroy Sante Lecture.** Call Mallinckrodt 314-362-7130.

16 thru 18 - *St. Louis:* **ATLS** Call St. Louis University 800-553-2712.

16 thru 18 - *St. Louis:* **Mental Health & Aging.** St. Louis University 800-553-2712.

19 thru 23 - *St. Louis:* **Medicolegal Death Investigator.** Call St. Louis University 800-553-2712.

22 thru 24 - *St. Louis:* **Surgical Approaches to the Skull Base.** 22 credit hours. Call Sandy Turck 314-535-4000.

23 thru 2 - *St. Louis:* **Oncology in the New Millennium.** Call Washington University 314-362-6287.

MAY

3 thru July - *St. Louis:* **Health Care Ethics in a Pluralistic Society: The Catholic Perspective.** Call St. Louis University 314-577-8167.

10 - *St. Louis:* **Musculoskeletal Radiology.** Call Mallinckrodt 314-362-7130.

JUNE

4 & 5 - *Branson:* **Update for Primary Care Physician.** Call St. Louis University 800-553-2712.

9 thru 11 - *St. Louis:* **Summer Geriatrics Institute.** Call St. Louis University 800-553-2712.

JULY

26 thru 29 - *St. Louis:* **Masters: Advanced Death Investigation.** Call St. Louis University 800-553-2712.

SEPTEMBER

29 thru 3 - *St. Louis:* **Sellar & Parasellar Pituitary Tumors.** 15 credit hours. Call Sandy Turck 314-535-4000.

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

Jean E. Birmingham, *St. Louis*
Jennifer H. Crawley, *Kansas City*
Wilfred Leach, *St. Louis*
Parley W. Madsen, *St. Louis*
Michael E. Monaco, *Kansas City*
Raymond D. Mossie, *Kansas City*
Abbiah N. Reddy, *Poplar Bluff*
Thomas C. Sparkman, *Cape Girardeau*
Joseph W. West, *Kirkwood*

New Members

MSMA

Milburn, James M. MD R
1003 Arlington Oaks Ter.
Chesterfield, MO 63017
Univ of MO-Kansas City 1990

Mitchell, Kevin J. MD GS
11155 Dunn Rd., #102N
St. Louis, MO 63136
Howard Univ-Washington, DC 1985

MID-MISSOURI

Caudill, Brent K. MD EM
482 Meramec Farm Rd.
Steelville, MO 65565
Indiana Univ-Indianapolis 1979

Kunkel, Glenn A. MD AN
1000 W. 10th
Rolla, MO 65401
Univ of Cincinnati 1986

Morgan, Scott C. MD U
1428 Hwy. 72 E.
Rolla, MO 65401
Rush Med Coll-Chicago 1993

Traino, Philip J. Jr. DO DR
604 W. 6th St., Bond Clinic
Rolla, MO 65401
Univ of New England-Biddeford, ME 1993

ST LOUIS METROPOLITAN

Brog, Michael A. MD P
11927 Mattox Ct.
St. Louis, MO 63131
St. Louis Univ 1988

Dowling, Joshua L. MD NS
660 S. Euclid, Box 8057
St. Louis, MO 63110
Tulane Univ-New Orleans 1989

Lewis, Lawrence M. MD EM
660 S. Euclid, Box 8072
St. Louis, MO 63110
Univ of Miami 1976

Manian, Farrin A. MD ID
621 S. New Ballas
St. Louis, MO 63141
Univ of MO-Columbia 1981

Philpott, Timothy C. MD OBG
3009 N. Ballas Rd., #A131
St. Louis, MO 63131
Washington Univ-St. Louis 1994

Popp, Dennis A. MD IM
621 S. New Ballas Rd., #3010
St. Louis, MO 63141
St. Louis Univ 1976

Schmidt, Maria E. MD DR
510 S. Kingshighway MIR
St. Louis, MO 63110
Yale Univ-New Haven, CT 1983

Stine, G. Wayne MD FP
16209 Trade Winds Ct.
Wildwood, MO 63040
St. Louis Univ 1972

SOUTH CENTRAL

Holloway, Walter R. MD U
1115 Alaska Ave., #215
West Plains, MO 65775
LA State Univ-Shreveport 1986

UM-COLUMBIA STUDENTS

Brockman, Jennifer E.
Luber, Kurre T.
Ramsey, Peter J.

UM-KANSAS CITY STUDENT

Choulakian, Armen

WASHINGTON U STUDENTS

Ahmad, Saad
Aveyard, Caitlin E.
Bang, Dae H.
Bartlett, Allison
Benedict, Christina H.
Besirli, Cagri G.
Beyer, Devra
Brown, Ty D.
Chan, Stanley
Chandra, Ritik
Cheng, Shan
Cheong, Monica
Chi, Tien-Hsin
Cloran, Francis J.
Denny, Matthew
Dorff, Jonathan
Dunn, Gavin
Ellis, Katherine E.
Elseby, Susan
Evason, Kimberley J.
Feng, Felix Y.
Foran, Erin
Galtor, Anat
Gelberman, Sara C.
Ghiz, Adam F.
Glatz, Andrew C.
Gore, Pankaj A.
Guillory, Robin
Gur-Lavi, Joy
Hadland, Brandon
Hall, Kristen L.
Hampton, David A.
Heaton, Jennifer J.
Hsu, Alice
Huang, Jennifer
Hunt, Darrell
Hurst, Eva
Imholt, Kristina M.
Ippolito, Joseph
Jaggars, Marissa
Johnston, James M. Jr.
Karpilskaya, Yekaterina
Kim, Edy
King, Erin
Klein, Jennifer M.
Klein, Sandra E.
Klenk, Alison
Koymen, Altug
Krejci, Elise
Kumar, Varun
Lane, Andrew
Larson, Michelle
Lien, Cindy
Lin, Lilie
Lin, Mary
Liou, Aimee
Lo, Mindy
Low, Siu Ping
Maas, James
Mahoney, Heather
Mann, Margaret
Martinez, Christopher
Martini, John A.
McClellan, James S.
Miki, Roberto
Miller, Jessica
Miner, Edward
Mitchell, Scott
Mogensen, Monique
Ofori, Abena
Ogden, A.M. Allison
Oh, Jung D.
Pao, Vivian
Partikian, Arthur
Patel, Maitraya
Patterson, J. Megan
Petka, Tanya M
Robinson, Darby
Roe, Taiyun
Shih, Robert
Shindel, Alan W.
Smith, Michael
Smith, Rebecca A.
Sun, Yoong
Suntharalingam, Mythili
Surana, Neeraj
Tadikamalla, Raghu
Takeshita, Junko
Tevaarwerk, Amye'
Thorne, Marc
Unger, Benjamin D.
Vemulakonda, Guranadh A.
Walker, J. Clinton
Ward, Christina M.
Williams, Kimberly
Wolff, Andrew B.
Woodruff, Lauren
Wu, Thomas Y.
Wunsch, Hannah
Yeh, Peter

UNIVERSITY HEALTH SCIENCES COLLEGE-KC STUDENTS

Haug, Darin L.
Leyh, Heather S.
McBridge, Megan C.
Nester, Kimberly A.
Watters, John L.
White, Frisco R.

KIRKSVILLE COLLEGE OF OSTEO MEDICINE STUDENTS

Moore, Angela C.
Robinson, Melissa R.
Shen, Mark
Winters, Chad A.

Missouri Physicians Health Program

MPH Program

Help for Physicians

The Missouri Physicians Health Program (MPH) is available to help Missouri physicians suffering from alcoholism, chemical dependency, and psychiatric illness. The aim of the program is to facilitate the professional functioning through early identification, intervention, and treatment.

This is a confidential service provided by the Missouri State Medical Association. The hotline is answered only by Jack L. Croughan, MD, Medical Director or Robert Bondurant, RN, LCSW, Program Coordinator. This is an opportunity to speak with a trained professional about any actual or possible impairment issue.

The MPH Program is available statewide. Representatives and services are located in principal urban centers to provide the most convenient access to services.

The Missouri Physicians Health Program has many years of experience in assisting physicians who are experiencing a variety of impairment issues. Access to the most appropriate sources for evaluation and treatment is available. A quality monitoring program is provided which has earned a strong reputation for credibility and therefore, a high degree of reliability in our effort to advocate for any Missouri physician.

A brochure and other educational information concerning the Missouri Physicians Health Program are available upon request. All inquiries are welcomed.

De Novo

for Spouses and Families of Missouri Physicians

De Novo means, "new beginning" and signifies hope and confidence in the future.

De Novo began as an adjunct to the Missouri Physicians Health Program when it was recognized that the spouses and families of these physicians could also benefit from similar services.

Confidentiality is a fundamental guarantee. The support groups are facilitated by an experienced professional and the participants are all from within the medical family community. This allows for a common understanding, as well as the promise of a safe environment where sensitive issues may be discussed with a strong sense of personal security.

Issues brought to the support group setting include substance abuse, mental illness, physical violence, relationship difficulties or any other subject that a family member perceives to be a problem.

The group facilitators are available to assist family members in identifying resources in addition to the group. They have the experience and knowledge to direct an individual to the appropriate community/professional resources.

The MSMA Alliance is a key supporter of the De Novo program. For more information, contact an Alliance member or call the number below.

Missouri Physicians Health Program
3839 Lindell Blvd., St. Louis, MO 63108
•Hotline: 1-800-274-0933 •Office: 314-995-4990 •Fax: 314-652-6033

Guide to Membership Benefits

MSMA offers value for your membership dues, the second lowest state medical association dues in the nation! Below are a some of the benefits MSMA members receive. For more information on membership, please contact MSMA at 573-636-5151.

- ❖ **Free subscriptions to *Missouri Medicine, Progress Notes,* and the *Legislative Report***
- ❖ **Physician's Guide to Law and Medicine**
- ❖ **Continuing Medical Education**
- ❖ **MoMed Net and MSMA's World Wide Web Site: http:www.msma.**
- ❖ **Credit Card Merchant Services**
- ❖ **MSMA Gold MasterCard**
- ❖ **Missouri Physicians Health Program**
- ❖ **Collection Services**
- ❖ **Tax Audit Service**
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Missouri Medicine

Journal of the Missouri State Medical Association
February 1999

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In This Issue...

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☐ Guide to Prescribing, Administering, and Dispensing Controlled Substances in Missouri
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☐ Trends in Missouri Lung Cancer Rates
☐ Salmonella Outbreaks in the Kansas City Metropolitan Area
☐ Urban-rural Differences in Medicare in Missouri

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On the Cover: "Studio Alcove" - by Ernest Feine (1894-1966). This 40" x 30" oil on canvas was painted in 1952. Feine said of the painting, "This section of my country studio contains various objects I have collected as possible subjects for paintings. The old wood burning stove is a great asset on cold winter days. The anatomy chart, palette, jugs and vases complete the studio environment." The painting is from the collection of Harry B. Cohen, MD, Columbia, Missouri, practicing anesthesiology in Mexico, Missouri.

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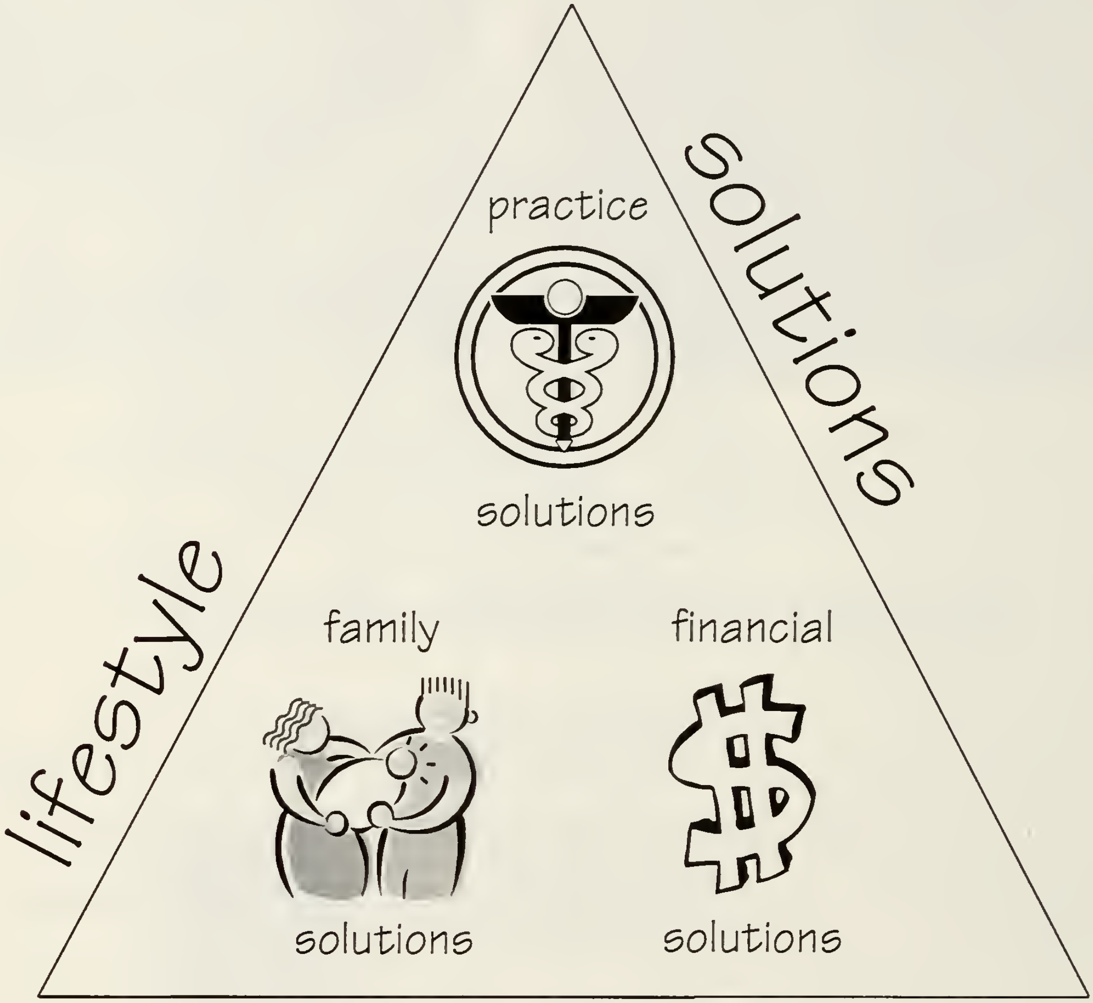
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Placebo Surgery

J. Regan Thomas, MD

It is to say the least, an interesting time to be practicing medicine. Technology and scientific breakthroughs with new drugs and therapies continue to develop at unprecedented speeds. The legislative and regulatory relationships that impact physicians and patients are tremendously different than a generation ago, while managed care and health care delivery are continuing to evolve and change. None the less, most physicians and patients will be surprised at the ready acceptance by some groups the concept of placebo surgery as part of a scientific surgical research program.

Double-blind controlled trials have been an important part of clinical scientific research. Most would agree that this approach enhances the data of any study and generally has made data of those studies designed in this fashion more meaningful and objective. A new research study using a placebo or "sham" operation which includes drilling two burr holes in the skull has some wondering if this project falls within acceptable standards. That is perhaps part of the problem. This concept as it relates to surgical procedures is new enough that most groups, such as the American College of Surgeons or the AMA, have no policy regarding the application of this approach.

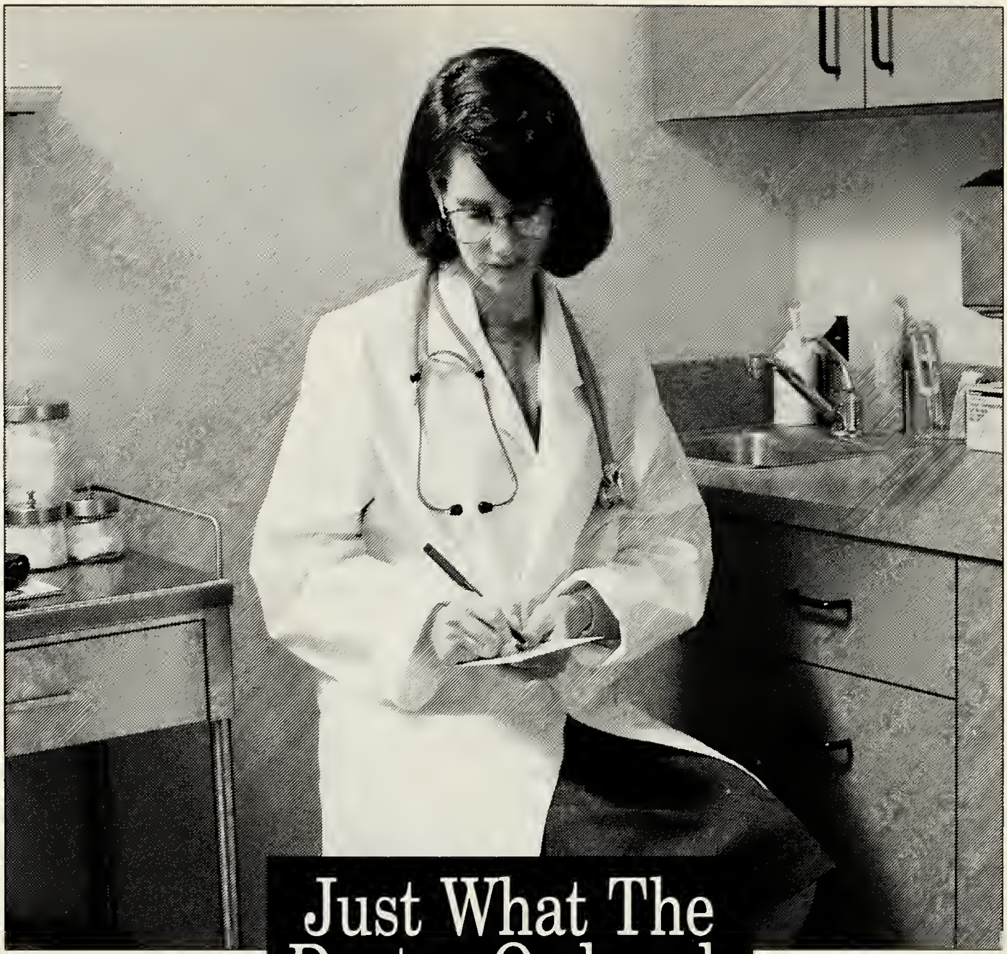
The *AMANews* in an article in January reported on studies being funded by the National Institute of Neurological Disorders and Stroke. They are exploring the usefulness of fetal tissue transplant in treating Parkinson's disease patients. In one study, patients from the Mt. Sinai Medical Center in New York and Rush Presbyterian Medical Center in Chicago are randomized to receive tissue transplant to the brain or given a sham surgery. These procedures are performed at the University of South Florida in Tampa and then followed at their home institution where the physicians will be "blind" as to whether the patient had the transplant or the sham procedure.

Those who favor this approach argue that it evaluates the effectiveness of the procedure in a more objective, scientific light of analysis. They predict that double-blind placebo control will be the gold standard to evaluate new surgical procedures (much as is done in new drug or pharmaceutical studies). Some predict that the government (or other payors) may begin to require such testing in the future before new procedures are accepted.

Those who are uncomfortable with this approach express concern about the safety of the control patients and also their true level of informed consent. In this study, for example, the control patients receiving the sham operation are sedated and given two burr holes. The proponents say this is minimal risk and quite safe for the patients. Some are condemning the study as unethical, concerned that the severity of the disease (Parkinson's) makes the patients so desperate they may be coerced into signing on to almost anything in hopes of relief. The proponents say that the importance of knowing the effectiveness of the treatment will benefit everyone. Also, they note that after being followed for two years, those patients who were randomized into the placebo-control group may have the real transplant procedure performed if they wish.

If the procedures are proven to be ineffective in helping the disease, then many individuals in the future would be saved from undergoing the operation. On the other hand, if it is effective, the data is much more objective and useful. Others argue that surgical procedures can be objectively studied through clinical trials by using alternative treatments instead of placebo-sham operations as the control group. Medical ethics groups are concerned that cost saving issues or similar economic based regulatory approaches may overshadow true patient informed consent should this become more widespread.

The issue will no doubt continue to stir more debates. We continue to practice medicine in interesting times. MoMed



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Proposed MSMA Constitution/Bylaws Changes

The following proposed changes in the MSMA Constitution and Bylaws were presented at the 1998 Annual Convention and will be voted on during the 1999 Annual Convention at the First House of Delegates. In accordance with the MSMA Constitution, these proposed changes must be published twice before being voted on. The bracketed items are deleted and the underlined items are added.

Article V. Council

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, Secretary, and Treasurer, and duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physicians Section, the Young Physicians Section, and the Organized Medical Staff Section. A majority of voting members of the Council shall constitute a quorum.

Article VIII. Officers

Section 2. The Officers shall be elected annually. The term of Councilors and Vice Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor, and organized medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilors and Vice Councilor from that district. The Delegates from the Medical Student Section, the Resident Physicians Section, the Young Physicians Section, and the Organized Medical Staff Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Article IX. Funds, Expenses and Budget

[Funds shall be raised by a per capital assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates.] The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

MSMA Bylaws

Chapter XIII. Dues and Assessments

Section 1. (a) The annual dues of this Association shall be set by the Council and payable by January 1 of the year for which they are levied. [$300, which shall be applicable to each active member of the Association beginning in 1987 and shall be levied per capita on the active members of the component societies; physicians leaving training programs and entering practice for the first time shall be assessed dues of $150 for the first calendar year and shall be Active members; physicians entering their second year of practice shall be assessed dues of $225 for the calendar year and shall be Active members; the per capita levy for Resident members shall be $20 per year; Student members shall be assessed dues of $5 per year; Honor members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Those members who join after July 1 of any given year shall be assessed at one-half of their regular dues rate, outlined in this section for the calendar year in which they join.] MoMed

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February 23 & 24, 1999

Alliance Day at the Legislature is an opportunity for physicians and their spouses to discuss issues with their elected officials. This day is well established at the Capitol and many legislators attend. *Spouses are not only welcome to join us both days – they are encouraged.*

Tuesday, February 23

2 p.m.	Deliver invitations to legislators
3:30 p.m.	Mid-Winter Board Meeting
6:30 p.m.	Cocktails/Dinner at Capitol Plaza Hotel MSMA lobbyist Tom Holloway will discuss current legislative issues

Wednesday, February 24

7:30 a.m.	Meet at the Capitol Building, lower level
8 a.m.	Legislators will begin to visit, coffee and rolls provided, you bring the conversation
10 a.m.	Observe sessions in the House and Senate or visit your legislator's office
11 a.m.	Tour of Cole County Historical Museum
Noon	Luncheon at Governor's Mansion/Whole House Tour

Alliance Day at the Legislature	**$25.00**
Governor's Mansion Luncheon	**$20.00**
Total Package Registration	**$45.00**

Register Soon!

Event deadline is February 10, 1999. *Seating is limited to 60 for Governor's Mansion.*

Name ______________________________

Address ______________________________

City/State/Zip ______________________________

County Society/Alliance ______________________________

List names of legislators you will personally invite ______________________________

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Complete form and send with appropriate fee payable to MSMAA to Eileen Chalk, 2108 Meadow Oaks Ln., Washington, MO 63090. Call Eileen at 314-390-2001 or fax registration to 314-239-0433.

Please note: A block of rooms has been reserved for MSMAA members. To make your hotel accommodations at the Capitol Plaza Hotel, call 573-635-1234 by February 10, 1999. After this date, rooms will be on sale to the public.

MSMA Takes Aim at Managed Care Hassles

Patrick J. Mills, MBA, CPA
MSMA Director of Health Care Finance

Are you tired of having claims denied after you obtained an authorization for your services? Are you getting nowhere with your phone calls?

The Missouri State Medical Association would like to help. Your responses to the following non-statistical survey will help MSMA identify how to best help you with your managed care hassles and identify the most common offenses.

Your office staff may be asked to supply additional information which will be necessary to substantiate the extent of the problem. When this is combined with documentation from other physicians, we will be in a much stronger position to reduce the administrative burden imposed on your practice by managed care.

Please take the time to fill out the form below and let us know your concerns. MoMed

Copy this page, fill out the information below and fax to 573-636-8552 or mail to MSMA, P.O. Box 1028, Jefferson City, MO 65102.

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☐ 2. Denial of Claim
☐ 3. Downcoding/Recoding of Claims
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☐ 6. "Missing" Claims Information
☐ 7. Denial of Preauthorization
☐ 8. Denial of Referral
☐ 9. Requests for Copy of Medical Record
☐ 10. Inaccurate Data Entry by Insurer
☐ 11. Requests for Operative Report
☐ 12. "Missing" Support Documents
☐ 13. Other Documentation Requests
☐ 14. Numerous Calls for a Single Claim
☐ 15. Pre/Post Payment Review
☐ 16. Telephone Always Busy
☐ 17. Excessive Telephone Hold Time
☐ 18. Other (please specify) ______________

____

____

A Guide to Prescribing, Administering, and Dispensing Controlled Substances in Missouri

Edited by:
Bert McClary, Assistant Administrator; Dirk W. Cable, Investigator
Bureau of Narcotics and Dangerous Drugs

This Guide to Prescribing, Administering, and Dispensing Controlled Substances in Missouri is being published with permission of the Missouri Task Force on Misuse, Abuse, and Diversion of Prescription Drugs.

This guide is published to assist and educate Missouri physicians in their handling of controlled substance issues. This edition includes changes to Missouri law that became effective in 1998

Task Force Suggestions and Cautions

Patient Care

- Do not prescribe in the absence of medical need. Do a workup sufficient to support a diagnosis, including all necessary tests.
- Determine what other drugs the patient is using. Obtain the names and addresses of any other practitioners the patient may be seeing. Verify the patient's current address.
- Use non-abusable drugs first or determine their inappropriateness through trial or documented history before beginning a regimen of controlled drugs.
- Take the time to explain to the patient the relative risks and benefits of the drug based on the information in FDA labeling requirements or professional drug literature.
- Maintain regular monitoring of the patient, including regular and frequent physical evaluation.
- Make sure you are in control of the supply of drugs.
- Maintain a thorough medical record that includes history and physical diagnosis, medical indication supporting the diagnosis, and a treatment plan with appropriate referrals.
- Keep detailed records of the patient's progress or lack of progress. Review frequently.
- Do not prescribe, dispense or administer controlled drugs outside the scope of your professional practice, or in the absence of a formal practitioner-patient relationship.

Drug Seeking Patients

- Be aware of the drug-seeking patient (*see* "What Are Common Characteristics of Drug-Seeking Patients?" on page 53).
- Secure your prescription pads.

Prescribing

- Do not presign prescription blanks or use signature stamps; an original signature is required.
- A prescription must be dated on the day it is issued; do not predate or postdate prescriptions.

Record Keeping

- Violations of state and federal controlled substance law occur most often in the area of required record keeping. Become familiar with the requirements of the law in this area. Maintain adequate records of all prescriptions, written orders, telephone orders and authorized refills, as well as all controlled substance dispensing and administration.

Registration Information

Controlled substances registrations from the Bureau of Narcotics and Dangerous Drugs (BNDD) and the federal Drug Enforcement Administration (DEA) are required for an individual practitioner to conduct any activities with controlled substances in Missouri. A DEA registration may not be required in certain situations. Individual practitioners include physicians, dentists, optometrists, podiatrists and veterinarians. Practice sites such as offices and clinics are not registered separately from individual practitioners.

Continued on page 48

Continued from page 47

Registered professional nurses may obtain BNDD registrations, but may not obtain DEA registrations, if they have collaborative practice arrangements with a physician. The nurse acts as an agent of the physician when administering or dispensing controlled substances, and the registration does not permit additional activities.

BNDD registration is required annually. DEA registration must be renewed every three years. The registration terminates if the practitioner discontinues practice at the registered location, and the practitioner may no longer prescribe, administer, dispense or possess controlled substances. BNDD must be notified at least three weeks prior to change of practice location.

- **Administering/Dispensing**
  A BNDD registration is required for administering or dispensing controlled substances. The registration may be maintained at any Missouri practice location, and allows the practitioner to administer and dispense from controlled substance supplies held under the registration of another practitioner. A DEA registration is not required if the practitioner only administers or dispenses (but does not prescribe) as an agent of another practitioner who is registered with BNDD and DEA.
- **Prescribing**
  A BNDD registration is required for prescribing controlled substances, either by writing, telephoning or faxing a prescription to be filled by a pharmacy. The registration may be maintained at any Missouri practice location. A DEA registration is required for prescribing except when the practitioner is an agent or employee of a hospital acting within the scope of employment of the hospital.
- **Maintaining Supplies**
  Both BNDD and DEA registrations are required for maintaining controlled substances supplies. Separate registrations must be maintained at each separate location where supplies are maintained. If supplies are received under more than one practitioner's DEA registration number at the same location, the supplies and required records must be kept separate.

A Guide to Prescribing, Administering and Dispensing Controlled Substances in Missouri

The abuse of prescription drugs – especially controlled substances – is a serious social and health problem in Missouri and the United States. As a practitioner, you share responsibility for solving the prescription drug abuse and diversion problem.

- You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.
- You have a professional responsibility to prescribe controlled substances appropriately, guarding against abuse while ensuring that your patients have medication available when they need it.
- You have a personal responsibility to protect your practice from becoming an easy target for drug diversion, which could result in legal actions against you and loss of your professional license. It is not the intent of these guidelines to limit or deny the access of legitimate patients to controlled substance medications of recognized and appropriate therapeutic value.
- You have a legal responsibility to acquaint yourself with the state and federal requirements for the prescribing and dispensing of controlled substances. Should you fail to abide by the requirements, you are subject to the loss or restriction of controlled substances privileges and discipline by the appropriate professional state licensing board.

This guide will help you meet these responsibilities. It summarizes key aspects of Missouri and federal controlled substances law and outlines common sense procedures that practitioners can use to prevent diversion of these drugs from their practice.

What Are Controlled Substances and Who "Controls" Them?

A controlled substance is a drug or drug product that comes under the jurisdiction of the federal Controlled Substances Act of 1970. The narcotic, depressant, stimulant, hallucinogenic and anabolic steroid drugs that are covered by the Controlled Substances Act (CSA) are listed in one of five schedules. Schedule I substances have no accepted medical use in the U.S. and have high abuse potential. Schedule II drugs have high abuse potential with severe psychic or physical dependence liability, and in general are substances that have therapeutic utility. Schedules III-V include drugs with decreasing levels of abuse potential. Representative examples listed on page 49 are by common name or

Continued on page 50

Schedules of Controlled Substances

COMMON EXAMPLES

SCHEDULE I - Drugs cannot be prescribed except in special research situations. There is no approved medical use.

fenethylline
peyote
heroin
LSD
marijuana
mescaline
MDMA
methaqualone (Quaalude)
DMA

SCHEDULE II - Maximum 30-day supply for any one prescription, no refills.* No phoned prescriptions except in emergency.

Schedule II Narcotic

morphine (Roxanol, MS-Contin)
codeine
fentanyl (Sublimaze)
sufentanil (Sufenta)
hydromorphone (Dilaudid)
meperidine (Demerol)
methadone (Dolophine)
oxycodone (Roxicodone, Percodan, Tylox)
oxymorphone (Numorphan)
opium
anileridine (Leritine)
diprenorphine (M50-50)
etorphine (M99)
cocaine
butyl nitrite (Rush)
LAAM

Schedule II Non-Narcotic

dextroamphetamine (Dexedrine)
methamphetamine (Desoxyn)
methylphenidate (Ritalin)
phenmetrazine (Preludin)
amobarbital (Amytal)
pentobarbital (Nembutal)
secobarbital (Seconal)
dronabinol (Marinol)
nabilone (Cesamet)
phencyclidine (PCP)
glutethimide (Doriden)

SCHEDULE III - Maximum 90-day supply, maximum five refills within a six-month period.* Phone prescriptions allowed.

Schedule III Narcotic

codeine (Tylenol w/codeine, Fiorinal w/codeine)
dihydrocodeine (Synalgos DC)
hydrocodone (Tussionex, Hycodan, Vicodin)
opium (paregoric)

Schedule III Non-Narcotic

butalbital (Fiorinal)
thiopental (Pentothal)
pentobarbital (Beuthanasia-D Special)
methyprylon (Noludar)
benzphetamine (Didrex)
phendimetrazine (Plegine, Bacarate)
testosterone
methyltestosterone (Oreton)
fluoxymesterone (Halotestin)
nandrolone (Deca-Durabolin)
tiletamine/zolazepam (Telazol)

SCHEDULE IV - Maximum 90-day supply, maximum five refills within a six-month period.* Phone prescriptions allowed.

ephedrine
dextropropoxyphene (Darvon, Darvocet)
codeine (Robitussin DAC, Terpin hydrate w/codeine)
pentazocine (Talwin)
alprazolam (Xanax)
chlordiazepoxide (Librium)
clonazepam (Klonopin)
clorazepate (Tranxene)
diazepam (Valium)
flurazepam (Dalmane)
lorazepam (Ativan)
midazolam (Versed)
temazepam (Restoril)
triazolam (Halcion)
zolpidem (Ambien)
barbital
mephobarbital (Mebaral)
phenobarbital
methohexital (Brevital)
chloral hydrate
ethchlorvynol (Placidyl)
meprobamate (Equanil)
paraldehyde
diethylpropion (Tenuate)
mazindol (Sanorex)
phentermine (Ionamin, Fastin, Adipex-P)
pemoline (Cylert)
fenfluramine (Pondimin)
dexfenfluramine (Redux)
flunitrazepam (Rohypnol)
butorphanol (Stadol, Torbugesic)
ketamine (Ketalar, Vetalar, Ketaset)

SCHEDULE V - Maximum 90-day supply; phone prescriptions allowed.

buprenorphine (Buprenex)
diphenoxylate (Lomotil)

EXEMPTED AND EXCLUDED SUBSTANCES

butalbital (Fioricet)
phenobarbital (Cafergot PB, Tedral)
chlordiazepoxide (Librax)
1-deoxyephedine (Vicks inhaler)
propylhexedrine (Benzedrex inhaler)

NONCONTROLLED ABUSED DRUGS

nalbuphine (Nubain)
dezocine (Dalgan)
carisoprodol (Soma)
tramadol (Ultram)

*See chart on page 51.

Continued from page 48

generic name, and some are accompanied by a common trade name in parentheses. There are some differences between federal and state listings of controlled substances.

The Comprehensive Drug Control Act of 1989, administered by the Bureau of Narcotics and Dangerous Drugs in the Missouri Department of Health, closely parallels the federal law. In some instances, however, Missouri's law is more stringent and takes precedence over federal law. For example, in Missouri, narcotic-containing cough syrups and certain ephedrine products are listed in Schedule IV and cannot be purchased without a prescription.

Missouri has established a diversion control and prevention program, coordinated among state and federal agencies, to identify and stop diversion. BNDD regularly evaluates drug purchases and other information and then reports suspected or potential diversion to the licensing agencies. These agencies further evaluate violations of law or standards of professional conduct, and proceed accordingly.

What Constitutes a Legitimate Prescription for a Controlled Substance?

Federal and state regulations clearly specify legitimate purposes for prescribing controlled substances:

- A prescription for a controlled substance is effective only if it is used for a legitimate medical purpose by a practitioner acting in the usual course of professional practice.

  Three criteria should be met:
  1. The patient must desire treatment for a legitimate illness or condition.
  2. A practitioner must establish a legitimate need through assessment, utilizing pertinent technical diagnostic modalities.
  3. There must be reasonable correlations between the drugs prescribed and the patient's legitimate needs.

- The Intractable Pain Act, passed in 1995, provides guidelines for the treatment of chronic, intractable pain. This law was intended to clarify the parameters for treating chronic pain with controlled substances. The physician must document the diagnosis and treatment of chronic pain in the patient record and the use of controlled substances must be therapeutic in nature and the manner utilized. Physicians may not prescribe or dispense controlled substances to a patient for chemical dependency unrelated to intractable pain or to a patient who the physician knows, or should know is using the medication in a nontherapeutic manner. Physicians may be subject to disciplinary action for nontherapeutic use of controlled substances, failing to keep accurate on-going treatment records, failing to keep complete and accurate controlled substance records, writing false or fictitious prescriptions, or prescribing controlled substances in a manner inconsistent with state or federal drug laws.
- Practitioners may not issue a prescription to obtain controlled substances for dispensing to patients. Practitioners must use DEA form 222 to obtain Schedule II controlled drugs.
- Controlled drugs for a practitioner's personal use must be prescribed by another appropriate practitioner, on the basis of an established practitioner/patient relationship. Practitioners are prohibited by law from prescribing or dispensing controlled drugs for personal use except in a medical emergency.
- It is recommended that practitioners do not prescribe, dispense or administer controlled drugs to office staff or family members. These activities may be investigated by both the appropriate professional state licensing board and BNDD. For dentists, veterinarians, podiatrists and optometrists certified to use therapeutic pharmaceutical agents licensed by their respective professional boards, the prescribing, administering, dispensing or distribution of controlled substances is limited to the scope of their respective professional practice after establishment of a practitioner/patient relationship. If the practitioner does prescribe, dispense or administer to office staff or family members, these individuals must be treated in the same manner as regular patients. This includes maintaining a chart, listing a diagnosis, plan of treatment and prognosis, and using the same documentation and care as with regular patients.
- Prescriptions may not be issued to dispense narcotic drugs for detoxification or maintenance treatment of a person who is dependent on narcotic drugs. However, a practitioner may

administer (but not prescribe) narcotic drugs to a patient daily for up to three days while arrangements are being made for referral to an existing narcotic treatment program.

How Do You Issue a Legal Prescription?

Prescriptions for controlled substances must be dated and signed on the day issued. A prescription also must include the following information:

- Name and address of the patient, including street and city,
- Name, address and DEA registration number of the practitioner,
- Signature of the practitioner,
- Name and quantity of drug prescribed,
- Directions for use.

It is the practitioner's responsibility to provide this information. It is the pharmacist's responsibility to verify that it is properly provided.

Practitioners who prescribe Schedule II controlled substances must maintain a record of all such prescriptions, either in the patient's chart or in a separate log. If the patient's chart is used, all Schedule II prescription information must be highlighted in some manner so as to be readily retrievable.

If a separate log is maintained for Schedule II prescriptions, which is highly recommended, the record should include the date, full name and address of the patient, the drug name, strength, dosage form, and quantity.

While Schedule III, IV and V controlled substance prescriptions are currently not required to be

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This table outlines state and federal limitations on prescriptions for controlled substances. Note: many limitations are more stringent for Schedule II prescriptions.

Prescription Characteristic	Limitation Schedule II	Limitation Schedule III and IV	Limitation Schedule V
Mode of issuing prescription	Written, verbal (only in a bona fide emergency)*, fax** or computer***	Written, verbal, fax** or computer***	Written, verbal, fax** or or computer***
Refills	None allowed - partial filling allowed for terminal patients or patients in long-term care facilities	Maximum of five within six months of issuing prescription	As authorized by practitioner
Length of prescription validity	Six months	Six months	One year
Quantity limitations****	30 days	90 days	90 days

*Emergency means that the immediate administration of the drugs is necessary for proper treatment, that no alternative treatment is available, and it is not possible to provide a written prescription order for the drug at that time. In the case of a bona fide emergency, a practitioner may telephone or transmit by fax a prescription order to a pharmacist for a controlled substance in Schedule II. In such a case, the drug prescribed must be limited to the amount needed to treat the patient during the emergency period. Within 72 hours, the practitioner must furnish to the pharmacy a written, signed prescription for the controlled substance prescribed. The pharmacist is required by law to notify DEA and BNDD if a written prescription is not received within 72 hours.

**All written, signed prescriptions may be transmitted by fax. When the drug is in Schedule II the original prescription must be presented to the pharmacist before dispensing, except when the prescription is for a long-term care facility resident or for certain narcotic injectable preparations. The face of the original prescription for all schedules must be signed and dated after transmission and the prescription filed chronologically at the practitioner?s office, except when the original Schedule II prescription must be presented to the pharmacist.

***The DEA approves computer prescription transmission only on an individual basis. When approved by DEA, Missouri regulations require the practitioner to maintain a signed printout of each day's transmissions, and the pharmacist must periodically verify prescriptions with the practitioner.

**** These quantities can be increased to a three-month supply if the physician describes on the prescription form the medical reason for requiring the larger supply.

Continued from page 51

entered in the patient chart, it is strongly recommended that all prescription and refill information be entered in the chart to confirm that controlled substance prescriptions were written or authorized.

What Procedures and Records Are Necessary for Dispensing and Administering?

The practitioner must provide direct supervision to employees who assist in administering and dispensing. Administering and dispensing cannot occur unless the practitioner is physically in the registered location, except when a registered nurse is administering or dispensing under a collaborative practice arrangement.

Under a collaborative practice arrangement with a physician, a registered nurse may administer or dispense controlled substances after direct consultation with the physician, within the nurse's scope of practice and consistent with their skill, training and competence. The nurse may not prescribe controlled substances. The nurse may obtain a Missouri Controlled Substances Registration, although it is not required and does not permit additional activities, but may not obtain a DEA registration. The collaborative practice physician must maintain BNDD and DEA registrations at the collaborative practice site and is responsible for all controlled substance activities, including purchasing controlled substances and authorizing receipt of controlled substance samples.

Drugs dispensed must be packaged in child-resistant containers and must be labeled with the date, the name and address of the practitioner, the name of the patient, the drug's name and strength, and directions for use.

Records must be maintained for two years for all controlled substances received, dispensed, administered or otherwise disposed of, including invoices, return receipts, dispensing, administration and destruction records.

A dispensing log must be maintained separate from the patient's medical record and must include:

- Complete patient name,
- Complete patient address, including city,
- Drug name, strength and dosage form,
- Quantity dispensed,
- Date dispensed,
- Name or initials of person dispensing.

A recommended dispensing/administration form is available from BNDD.

Administration records must contain the same information as dispensing records. Although they may be kept in the patient's medical record, they must be readily retrievable. It is recommended they be kept on the dispensing/administration log.

A complete inventory must be recorded every two years. A continuous (perpetual) inventory is also recommended and can be conveniently maintained as part of the dispensing/administration log for each drug. Note that a perpetual inventory does not fulfill the requirement for a complete inventory taken every two years.

Records must be kept of controlled substances transferred or distributed to other practitioners or other office locations. A license from the Missouri State Board of Pharmacy may be required in certain situations.

Expired or unwanted controlled substances may not be destroyed by the practitioner except in special circumstances when permission is granted by DEA. They may be returned to the original supplier using DEA Form 222 for Schedule II or a proper record of transfer for Schedules III-V. They may also be transferred to a DEA-registered "reverse distributor" company. A list of these companies is available from BNDD or DEA. Partially used dosage units such as syringes and single-use ampuls may be destroyed if the destruction is witnessed and documented by two persons.

Controlled substance samples must be treated in the same manner as any other controlled substance, including receiving, inventory, dispensing and destruction records. Procedures for packaging and labeling when dispensing must be followed.

If more than one practitioner in the same office receives controlled substances (including samples) under separate DEA registrations, all records and supplies must be maintained separately. Contact BNDD for procedures to combine records and supplies under a primary practitioner in group practice situations.

Where Should Controlled Substances Be Stored?

Under federal law, practitioners must store controlled substances in their offices or clinics in a securely locked, substantially constructed cabinet or safe. Access to the storage area should be restricted to persons specifically authorized to handle controlled substances.

Any loss or theft of controlled substances or DEA order forms must be reported to DEA and BNDD. Contact BNDD at 573/751-6321 for loss reporting forms. Thefts of controlled substances should be reported to local police.

What Can Practitioners Do to Prevent Diversion and Prescription Drug Abuse?

Adherence to state and federal regulations goes a long way in protecting your practice from becoming a source of drug diversion and prescription drug abuse. Forged and altered prescriptions are a major source of drug diversion.

Suggestions for Practitioners:

- Store all unused prescription pads in an appropriately secure/locked place.
- Minimize the number of pads in use at one time.
- Have prescription blanks numbered consecutively when printed so you can tell if some sheets are missing.
- Never sign prescription blanks in advance.
- Write out the actual amount of medication prescribed in addition to using an Arabic or Roman numeral.
- Write prescriptions in ink or indelible pencil to prevent changes.
- Do not use your prescription blanks for writing notes or memos.
- Do not leave prescription pads in unattended examining rooms, office areas or in your bag or car where they can be easily picked up.
- Respond to a pharmacist's request for prescription verification. It is the responsibility of the pharmacist to deny the prescription without sufficient verification.

What Are Common Characteristics of Drug-Seeking Patients?

The drug-seeking patient, also known as a "professional patient," is usually unfamiliar to the practitioner, but may become a regular patient if he or she finds the practitioner easy to manipulate in obtaining desired medications. The person may claim to be from out-of-town and has lost or forgotten a prescription of medication. Abusers may contend to be a patient of a practitioner who is currently unavailable, and ask for a prescription renewal. Drug seekers generally have no interest in diagnosis, fail to keep appointments for further diagnostic tests or refuse to see another practitioner for consultation. Drug-seeking patients may involve children or the elderly in their scams.

Manipulative Approaches Often Used by the Drug-Seeking Patient Include:

- Feigning physical problems, such as back pain, kidney stone or headache in an effort to obtain narcotic drugs.
- Feigning psychological problems, such as anxiety, insomnia, fatigue or depression in an effort to obtain stimulants or depressants.
- Deceiving the practitioner, such as by requesting refills more often than originally prescribed.
- Pressuring the practitioner by eliciting sympathy or guilt, or by direct threats.
- Feigning narcolepsy in an effort to obtain amphetamines or methylphenidate.

What Should a Practitioner Do When Confronted by a Suspected Drug-Seeking Patient?

1. Be alert for "scams." See *Scam of the Month* booklet.

2. Watch for these signs of a drug-seeking patient:

- a new patient coming for pain, age 25-45,
- residence is distant from your office,
- patient claims to be referred by another practitioner,
- unusual behavior in waiting room,
- appearance – extremes of slovenliness or being over-dressed,
- patient frequently appears when you are about to commence rounds, or frequently appears on Friday afternoon,
- inconsistent signs of acute pain – no signs displayed while waiting but the patient commences to show symptoms when in examination room,
- gives history with textbook symptoms,
- physical exam shows evidence of treatment by other practitioners or of addiction,
- patient shows unusual knowledge of controlled substances,
- patient requests a specific controlled drug,
- patient is reluctant to try a different drug,
- asks for a Schedule IV drug initially, but calls back or revisits asking for a Schedule II.

Continued on page 54

Continued from page 53

3. **Examination and documentation:**
   - Always perform a thorough exam appropriate to condition.
   - Always document examination results and questions you asked the patient.

   Questions the treating physician should ask:
   - What other practitioners are you currently seeing for this or any other condition?
   - When did you last see other practitioner?
   - What drugs have been prescribed for this condition?
   - Are you currently taking any controlled drugs?
   - What controlled drugs, strength and frequency?
   - What over-the-counter drugs are you currently taking?
   - Have you ever been treated for alcohol or chemical dependency?

   - Written answers to these questions on a form are helpful.
   - Discuss standard procedure for evaluating new patients requiring controlled drugs.
   - Request picture I.D., or other I.D. and Social Security number; copy and include in chart.
   - Call previous practitioner, pharmacist or hospital to confirm.
   - Confirm telephone number if provided by patient.
   - Write prescriptions for limited quantities.
   - Confirm current address at each visit.

4. **Sharing information on patients:**
   - Contact local law enforcement and BNDD.
   - Attempting to obtain a controlled substance by fraud, deceit or misrepresentation is a felony, and information communicated to a practitioner in these circumstances is not privileged.
   - Use the phrase "A person using the name _________ attempted to . . ."
   - Keep any list of suspects confidential.
   - Persons who provide information to the BNDD in good faith are not subject to civil damages as a result.

Know Yourself and Your Practice – Practitioners as Sources of Drug Diversion

The American Medical Association outlines four types of practitioners, the "Four D's," who are sources of drug diversion. If you or a colleague fit one of these categories, it's time to evaluate your practice or demonstrate peer concern.

- **Dishonest** – or "script" – practitioners, who willfully and knowingly prescribe controlled drugs for purposes of abuse and usually for profit.
- **Disabled** – or impaired – practitioners, whose professional competence has been impaired by drug abuse, alcoholism or other physical or mental disorders.
- **Deceived** practitioners who unwittingly acquiesce to some patients' insistent demands for medication. Typically, these practitioners prescribe drugs in larger amounts or for longer periods of time than are medically indicated.
- **Dated** practitioners who have not kept pace with developments in pharmacology or drug therapy. These practitioners are poor prescribers, not because they intend to be, but because they lack information or understanding. They may be prescribing excessive amounts of drugs for exceptionally long periods of time, prescribing types of drugs that are not indicated for the condition or prescribing drugs when another type of therapy is indicated.

Recognition and Appreciation

This Missouri Task Force publication was made possible by generous financial support provided through the Missouri Pharmaceutical Manufacturers Association.

For Additional Information, Contact:

Bureau of Narcotics and Dangerous Drugs
P.O. Box 570
Jefferson City, MO 65102
573/751-6321

Caution

The purpose of this information is to educate and inform the prescriber of the regulations and statutes pertaining to controlled substances. It is not the intent to reduce or deny the use of controlled substances where medically indicated. Nothing in this booklet shall be construed as authorizing or permitting any person to do any act that is not authorized or permitted under other federal or state laws. In addition, none of the policy and information in this booklet may be construed as authorizing or permitting any person to do any act that is not authorized, or refuse to meet any requirements imposed under the regulations published in the most recent publication of the Code of State Regulations or the Revised Statutes of Missouri. MoMed

Radiology Quiz

Roger A. Francis, MD, FACR
Diagnostic Imaging Department
Nevada Regional Medical Center

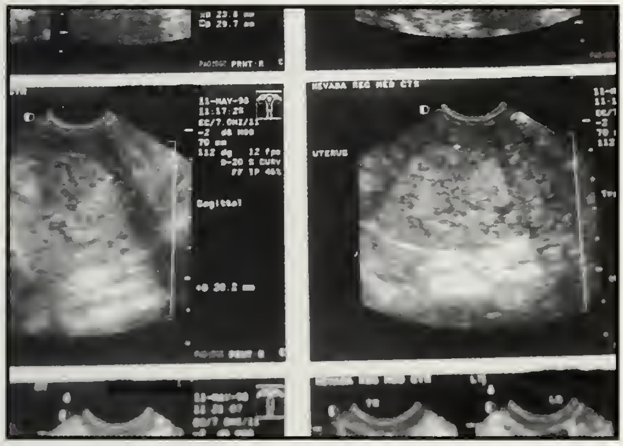

Figure 1

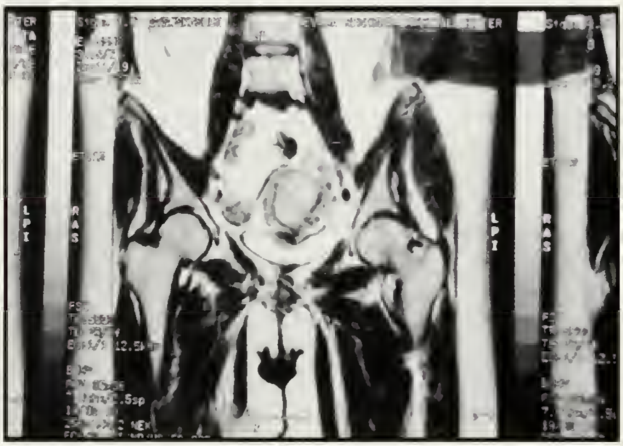

Figure 2

A 59-year-old female presented to the clinic with a one week history of postmenopausal bleeding and spotting. As part of the workup, endovaginal pelvic ultrasonography (Figure 1) and pelvic MRI (Figure 2) were performed.

1. **What is the most likely diagnosis**

   a. Ovarian carcinoma
   b. Endometrial carcinoma
   c. Uterine leiomyoma
   d. Cervical carcinoma

(See answers on next page.)

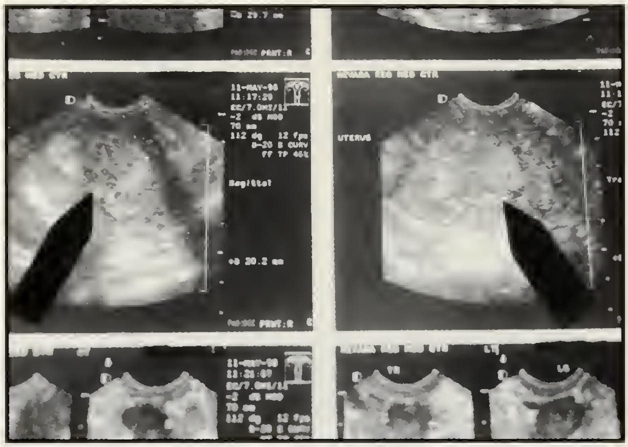

Figure 1 repeated

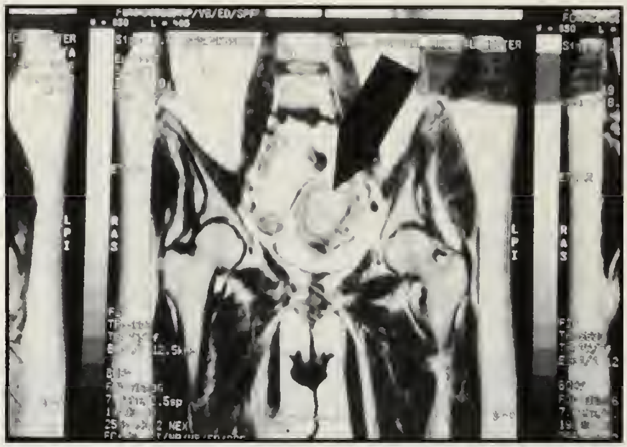

Figure 2 repeated

ANSWER
b - Endometrial carcinoma

Saggital and transverse endovaginal ultrasound images of the uterus show the endometrium (arrows, Figure 1) to be thickened, measuring 2 cm in thickness. Normal endometrial thickness in a postmenopausal patient who is not on hormone replacement therapy is less than 5 mm. The T2 weighted coronal MRI image (Figure 2), confirms endometrial mass or thickening (arrow). Due to endometrial findings on imaging studies, endometrial biopsy was performed, yielding a diagnosis of moderately differentiated adenocarcinoma.

In patients presenting with postmenopausal bleeding, endovaginal ultrasound is a fast, inexpensive and noninvasive method for selecting patients who need further workup or biopsy. A review article in the November 4, 1998, issue of *JAMA* concluded that women with postmenopausal bleeding and endometrial thickness of less than 5 mm on endovaginal sonography were highly unlikely to have endometrial carcinoma, whereas those with endometrial thickness of 5 mm or greater had sufficient likelihood of endometrial carcinoma to warrant biopsy.

In patients who are diagnosed with endometrial carcinoma, additional imaging studies may be helpful in preoperative staging. T2 weighted MRI imaging of the uterus are particularly useful in determining the depth of myometrial invasion. Both MRI and CT are helpful in looking for lymph node enlargement or other signs of local or distant metastases.

Ovarian carcinoma is unlikely since imaging abnormalities clearly involve the uterus rather than ovaries.

Uterine leiomyoma would be unlikely to cause endometrial mass or thickening.

Cervical carcinoma may show no imaging abnormalities, but advanced cervical carcinoma may cause a bulky appearance of the cervix on ultrasound, CT or MRI. MoMed

Reference:

•Edelman R, Hesselink J, Zlatkin M. Ed. *Clinical Magnetic Resonance Imaging*, 2nd Edition, Saunders 1996, pp 1450-1453.
•Rumack C, Wilson S, Charboneau J. *Diagnostic Ultrasound*, 2nd Edition, Mosby 1998, pp 535-540.
•Smith-Bindman R, et al. Endovaginal Ultrasound to Exclude Endometrial Cancer and Other Endometrial Anomalies. *JAMA* Nov 4, 1998, 260;17:1510-1517.

Missouri State Medical Association

141st Annual Convention
April 8-11, 1999

Tan-Tar-A Resort • Osage Beach, Missouri

MSMA Sponsored Annual Meetings and Events

Thursday, April 8

10:00-Noon	Opening Session, MSMA House of Delegates
1:30 pm	MSMA Reference Committees

Friday, April 9

9:00-10:30 am	MSMA General Session
11:00-12:30 pm	MSMA General Session
11:00-1:00 pm	Medical Student Delegate Luncheon
Noon-2:00 pm	General Session
1:00-2:00 pm	MSMA Organized Medical Staff Section
1:30-4:00 pm	MSMA General Session
4:00-6:00 pm	Second Session, MSMA House of Delegates

Saturday, April 10

8:00-Noon	MSMA Section on Young Physicians/International Medical Graduate Program
1:00-2:00 pm	Open Forum on AMA Issues
6:30-7:30 pm	MSMA Presidential Inauguration
7:30-9:00 pm	MSMA Reception

Sunday, April 11

7:30 am	Final Session, MSMA House of Delegates Breakfast Meeting

1999 MSMA Preregistration

Name

Mailing Address

Component Medical Society

PLEASE RETURN TO
MSMA, PO BOX 1028, JEFFERSON CITY, MO 65102
FAX 573-636-8552

☐ Delegate ☐ Member

Please complete and mail the above preregistration form to assure a quick on-site registration. Upon receipt of your preregistration form, you will be mailed a confirmation card to present at the convention registration desk. Your registration packet and name badge will be awaiting your arrival.

Also, please complete and mail (directly to Tan-Tar-A) the hotel reservation form below at your earliest convenience. Reservation deadline is February 19, 1999.

Hotel Reservation

Missouri State Medical Association's Annual Convention • *April 8-11, 1999*

Tan-Tar-A Resort Osage Beach, MO 573-348-3131

Name: ____________________
Address: ____________________
City: ____________________ State/Zip: ____________________
Telephone: __________ Arrival Date: __________ Arrival Time: __________ Departure Date: __________
Number of Persons: __________ Number of Rooms: __________
Payment Method: Cash/Check: __________ Credit Card #: __________ Exp. Date: __________

Should you require accommodations with no steps due to a physical condition (wheel chair use, crutches, etc.), please indicate this.

Reservations are accepted on a space-available basis, so it is important to get your reservation in as soon as possible. Reservations will be accepted and confirmed up to the opening day of the convention, providing accommodations still are available. Reservations run from 4 p.m. on day of arrival until noon on day of departure.

PLEASE LIST NAMES OF ALL PERSONS SHARING SAME ACCOMMODATIONS.

ACCOMMODATIONS

Single/Double Occupancy	$90 per room/per day + tax
One-Bedroom Suites	$165 per room/per day + tax
Two-Bedroom Suites	$215 per room/per day + tax

Please indicate preference for room with ____ 1 bed ____ 2 beds ____smoking ____ nonsmoking

Cancellation Policy - We require an advance of one night's lodging or credit card guarantee to confirm reservations. Deposits are refunded/credited only when cancellation notice reaches the Tan-Tar-A office 72 hours prior to the day of arrival. Your deposit will be forfeited if you arrive later or depart earlier than the indicated date.

PLEASE RETURN FORM AND DEPOSIT TO:
MARRIOTT'S TAN-TAR-A RESORT RESERVATIONS DEPARTMENT PO BOX 188TT OSAGE BEACH, MO 65065-0861
ALL MAJOR CREDIT CARDS WILL BE ACCEPTED BOTH FOR PAYMENT AND DEPOSIT.

Annual Meetings and Events

Thursday, April 8

7:00-4:00 pm	MSMA Registration
7:00-9:30 am	Moneta Breakfast
10:00-Noon	Opening Session MSMA House of Delegates
11:45-1:00 pm	St. Louis Metropolitan Medical Society Luncheon Caucus
Noon-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon Caucus
1:30 pm	MSMA Reference Committees Meeting
4:00-6:00 pm	MSMAA Registration
7:00 pm	MSMAA Dutch Treat Dinner

Friday, April 9

7:00-4:00 pm	MSMA Registration
7:00-8:30 am	Councilor Districts #1,2,5,6,8,9,10 Breakfast Meetings
7:30-8:30 am	MSMAA Continental Breakfast
7:30-9:00 am	University of Missouri-Columbia Alumni Organization Board of Governors Breakfast Meeting
7:30-2:00 pm	MSMAA Registration
8:30-11:30 am	MSMAA General Assembly
9:00-10:30 am	MSMA General Session
11:00-12:30 pm	Missouri Society of Otolaryngology - Head and Neck Surgery Scientific Presentation
11:00-12:30 pm	Missouri Dermatological Society, Inc. Scientific Presentation
11:00-12:30 pm	MSMA General Session
11:00-1:00 pm	Medical Student Delegate Luncheon
Noon-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon
Noon-2:00 pm	MSMA/Alliance General Session
12:30-2:00 pm	University of Missouri-Columbia Alumni Luncheon
1:00-2:00 pm	Missouri Society of Otolaryngology-Head and Neck Surgery Scientific Presentation
1:00-2:00 pm	MSMA Organized Medical Staff Section Business Session
1:00-4:00 pm	Missouri Chapter, American Academy of Pediatrics Scientific Presentation
1:30-3:00 pm	Missouri State Surgical Society Scientific Presentation
1:30-4:00 pm	MSMA General Session
2:00-4:00 pm	St. Louis Metropolitan Medical Society Caucus
2:45-4:00 pm	Missouri State Medical Foundation Business Meeting
4:00-6:00 pm	Second Session MSMA House of Delegates
6:00 pm	Missouri Society of Eye Physicians and Surgeons Board of Directors Dinner Meeting
6:00-7:30 pm	University of Missouri-Kansas City, Washington University School of Medicine, University of Missouri-Columbia, St. Louis University School of Medicine Alumni Receptions
7:30-11:00 pm	AMA-ERF Fundraiser

Annual Meetings and Events

Saturday, April 10	
7:00-2:00 pm	MSMA Registration
7:00 am	Missouri Association of Plastic and Reconstructive Surgeons Breakfast Meeting
7:00-9:00 am	Missouri Society of Otolaryngology-Head and Neck Surgery Breakfast Business Meeting
7:30 am	MSMAA Past Presidents Breakfast
7:30-8:15 am	Missouri Society of Eye Physicians and Surgeons Breakfast Meeting
8:00-10:00 am	MSMAA Registration
8:00-11:00 am	Missouri Academy of Family Physicians Scientific Presentation
8:00-11:30 am	Missouri Association of Plastic and Reconstructive Surgeons Scientific Presentation
8:00-Noon	MSMA Section on Young Physicians/International Medical Graduate Program
8:30-Noon	Missouri Society of Eye Physicians and Surgeons Scientific Presentation
8:30-Noon	MSMAA General Assembly Second Session
9:00-10:30 am	Missouri State Neurological Association Scientific Presentation
9:00-11:30 am	Missouri State Surgical Society Scientific Presentation
9:00-11:30 am	MSMAA General Assembly
9:15-Noon	Missouri Society of Otolaryngology-Head and Neck Surgery Scientific Presentation
9:30-11:30 am	Christian Medical and Dental Society Scientific Presentation
11:00-Noon	MMPAC Meeting
Noon	MSMAA Installation-Awards Luncheon
Noon	Missouri Society of Otolaryngology-Head and Neck Surgery Luncheon
Noon	Missouri Society of Eye Physicians and Surgeons Luncheon
Noon	Missouri Association of Plastic and Reconstructive Surgeons Luncheon
Noon	Missouri Radiologic Society Luncheon
Noon	Missouri State Surgical Society Luncheon
1:00 pm	Missouri Association of Plastic and Reconstructive Surgeons Scientific Presentation
1:00-2:00 pm	Open Forum on AMA Issues
1:00-4:00 pm	Missouri Radiological Society Scientific Presentation
1:00-4:00 pm	Missouri Society of Eye Physicians and Surgeons Scientific Presentation
1:00-4:00 pm	Missouri Chapter, American Academy of Pediatrics, MSMAA Scientific Presentation
1:00-5:00 pm	Missouri Chapter, American College of Emergency Physicians Mini-Conference Presentation
3:00 pm	MSMAA Joint Convention Board Meeting
6:30-7:30 pm	MSMA Presidential Inauguration
7:30-9:00 pm	MSMA/MSMAA Presidential Reception

Sunday, April 11	
7:30-9:00 am	Final Session MSMA House of Delegates
9:30-11:30 am	Christian Medical and Dental Society

MISSOURI SOCIETY OF EYE PHYSICIANS AND SURGEONS

Saturday, April 10, 1999	7:30-Noon	Scientific Program
	1:00-4:00 pm	Scientific Program

Scientific Program
(sponsored by the Missouri Society of Eye Physicians and Surgeons

Moderator: Thomas Whittaker, MD

7:30 am
Refractive Surgery - What's New?
John Doane, MD
8:30 am
Ocular Inflammatory Disease
Ronald E. Smith, MD
10:00 am
Glaucoma, Retina and Anterior Segment Update
1:00 pm
Impact of Medical Record Documentation and Coding on Patient Care
Ms. Joy Newby
3:00 pm
Principles of Risk Management in the Ophthalmologist's Office
Paul Weber, JD

Objectives: Following the educational offering, participants will have a better understanding of: 1) Current opinions and research on ocular and systemic inflammatory disease with emphasis on diagnostic and treatment options; 2) Current controversies in ophthalmic subspecialties including glaucoma, retina, anterior segment and refractive surgery, and 3) Current practice modalities and their impact on patient care.

Needs: The procedures utilized to determine physician needs and interests were: 1) Annual survey of membership which includes questions concerning topics members would like to see in a scientific prgoram, 2) Board of Directors discussion of possible program topics based on their own experiences and discussions with colleagues back home, 3) Review of AAO annual meeting and other ophthalmology society programs, and 4) Review of current journals.

Other Activities
(sponsored by the Missouri Society of Eye Physicians and Surgeons)

Friday
6:00 pm
Board of Directors Dinner Meeting

Saturday
7:30 am
Breakfast with Meeting
12:00 noon
Luncheon

Missouri Medicine

Journal of the Missouri State Medical Association

MSMA Art Exhibit . . .

MSMA members interested in art are urged to submit their work for the MSMA Art Exhibit at the 1999 Annual Convention. The artwork will be displayed in the exhibit hall and judged by the members. The winner will be featured on the cover of our journal.

For more information please call Michelle Poire, Managing Editor at 573-636-5151.

MISSOURI SOCIETY OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY

Friday, April 9, 1999	11:00-12:30, 1:00-2:00 pm	Scientific Program
Saturday, April 10, 1999	9:15-1:15 pm	Scientific Program

Scientific Program
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Moderator: Greg Renner, MD

Friday
11:00-12:30 pm
The Diagnosis and Treatment of Obstructive Sleep Apnea
Jerry Templer, MD
1:00-2:00 pm
Identification and Management of Cutaneous Lesions of the Head and Neck
Greg Renner, MD

Objectives: Following the scientific program, participants will have a better understanding of: 1) Pediatric sleep apnea and localization of the obstruction and proper examination of aerodigestive tracts, 2) Early recognition, treatment and prevention of obstructive sleep apnea, 3) Conditions associated with both central and obstructive apnea, 4) Sciences involved in sleep and the relationship of Obstructive Sleep Apnea Syndrome, 5) Early recognition and treatment of basal, squamous and melanomatous lesions, and 6) Principles and methods of treatment of all aspects of skin cancer of the head and neck for family physicians and internists.

Saturday
9:15-Noon
Scientific Program
Noon-1:15 pm
Luncheon Program

Other Activities
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Saturday
7:00-9:00 am
Business and Breakfast Meeting
Noon
Luncheon with Program

Mark your calendars now and plan to join your colleagues at the beautiful Lake of the Ozarks.

MISSOURI CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Friday, April 9	1:00-4:00 pm	Scientific Program
Saturday, April 10	1:00-4:00 pm	Scientific Program

Scientific Program
(Missouri Chapter, American Academy of Pediatrics)

Moderator: Bernard Griesemer, MD

Friday
1:00-4:00 pm
Media Literacy for Teenagers
Bernard A. Griesemer, MD
PG13 Rated - Sexually Transmitted Diseases in the Middle School Ages
Bernard A. Griesemer, MD
How to Get Involved in School Based Health Care
Daryl Lynch, MD
Firearms Injury Prevention and Children
Denise Dowd, MD

Saturday
1:00-4:00 pm
Same as Friday's program, co-sponsored by the Missouri State Medical Association Alliance.

MISSOURI RADIOLOGIC SOCIETY

Saturday, April 10 1:00-4:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Radiologic Society)

1:00 pm
ACR Compliance Program Guidelines
Thomas R. Hoffman, MD

2:00 pm
Medicine and the Information Superhighway
John Oro, MD

3:00 pm
Missouri Healthcare Legislation
Harvey Tettlebaum, Esq.

Objectives: After this program, participants will have a better understanding of: 1) Principles of a compliance program and how this may be implemented, 2) How medicine is using the information superhighway, and 3) The impact of Missouri Legislation on patient care.

Other Activities
(sponsored by the Missouri Radiologic Society)

Saturday
8:00-10:00 am
Breakfast
Noon
Luncheon Meeting

MISSOURI PSYCHIATRIC ASSOCIATION

MISSOURI SECTION, AMERICAN COLLEGE OF OB-GYN

MISSOURI CHAPTER, AMERICAN COLLEGE OF EMERGENCY MEDICINE

Saturday, April 10 1:00-5:00 pm Scientific Program

Scientific Program
(sponsored by Missouri Chapter, American College of Emergency Medicine, Missouri Psychiatric Association, and the Missouri Section, American College of OB-GYN

Medicine and the Law: Mini-Conference on the Federal EMTALA/COBRA Regulations

1:00 pm
The Basics of the EMTALA/COBRA Provisions
Howard A. Peth, Jr., MD

2:00 pm
Mechanics of the HCFA Investigation: What They Look for and How to Respond
Yolanda Richardson, RN

3:00 pm
The HCFA Medical Review: Where There's Smoke There's Fire
Ronald P. Rae, MD

Objectives: At the conclusion of this mini-conference, the participants will be able to: 1) State the legal requirements involved in patient transfers, 2) Define the terms patient transfer, medical screening examination, and stabilization, 3) Explain the emergency consent theory and how to evaluate a patient's capacity to give consent, 4) Understand the procedures employed by US federal and State of Missouri regulatory authorities in conducting investigations into alleged EMTALA violations, 5) Discuss the scope of sanctions available to HCFA in enforcing alleged EMTALA/COBRA violations, 6) Implement an effective EMTALA compliance program at your hospital, and 7) Understand how to respond to HCFA investigation into alleged EMTALA./COBRA violations.

4:00 pm
Informed Consent: Transfer Requests and Treatment Refusals Emergency Management of the Difficult Patient
Howard A. Peth, Jr., MD

ANNUAL CONVENTION

General Sessions

Preserving the Physician-Patient Relationship in a Managed Care Environment

Friday, April 9 • 9:00 - 10:30 a.m.

Interactive Seminar Building Bridges: Enhancing the Physician-Patient Partnership

Friday, April 9 • 1:30 - 4:00 p.m.

Physicians are encouraged to make reservations for the Interactive Seminar.

Y2K

Practical Tips on How You Can Survive

Friday, April 9

11:00 a.m. - Noon

Presented by:
Eugene R. Worth, MD, MEd
President, Medical Information Technologies
Columbia

Domestic Violence:

Recognition, Intervention, Documentation

Friday, April 9 • Noon - 2:00 p.m.

Presented by: Zita Surprenant, MD, Lenexa, Kansas

A Joint Luncheon and Scientific Program sponsored by the Missouri State Medical Association and Alliance.

The MSMA Alliance presents:

"Mystery Dinner Theater"

Dinner and Silent Auction

Friday, April 9 • 7:30 p.m.
Tan-Tar-A Resort
$60/person

Proceeds to benefit AMA-Foundation

Anatomy of a Contract

Saturday, April 10 • 8:00 - 10:00 a.m.

Speaker: Randy S. Gerber
Attorney, Gallop, Johnson & Neuman, L.C., St. Louis

For session to be effective, members are asked to forward contracting issues to MSMA.

PREREGISTRATION

Preregistration for MSMA's 1999 Annual Convention makes it easy for everyone! Fax the enclosed form 573-636-8552, mail it to us at: P.O. Box 1028, Jefferson City, MO 65102, or register over the Internet at www.msma.org.

Check the General Sessions you will be attending:

____ *Preserving Physician-Patient Relationship*
____ *Interactive Workshop*
____ *Y2K*
____ *Domestic Violence (Reservations Required)*
____ *Anatomy of a Contract*

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Trends in Missouri Lung Cancer Rates

Nancy Miller, MEd, CHES; Eduardo J. Simoes, MD, MPH; Jian C. Chang, PhD

Abstract

This study presents trend analysis of Missouri lung cancer incidence and mortality, and makes comparisons to U.S. rates. Utilizing 1985-1992 data from the Missouri Cancer Registry, we calculated incidence rates by disease diagnosis year. Missouri Center for Health Information Management and Epidemiology data were used to calculate 1980-1996 mortality rates. Missouri's overall yearly lung cancer incidence rate increased from 60.5 to 62.5 per 100,000 during 1985-1992, while lung cancer mortality increased 25% from 1980-1996. The best method to reduce Missouri's rates of lung cancer is tobacco-use prevention and cessation.

Background

In the United States (U.S.), lung cancer is responsible for more than 160,400 deaths each year – more deaths than from breast, colon, urinary system, and prostate cancer combined.[1] In Missouri, lung cancer claimed 3,687 lives in 1996, slightly fewer than that from stroke, the third leading cause of death. This study presents trend analysis of Missouri lung cancer incidence data from 1985-1992 and mortality data from 1980-1996, and makes comparisons to U.S. rates.

Although lung cancer is linked to a number of risk factors such as exposure to asbestos, arsenic, radiation, and radon, the primary cause is cigarette smoking, which is responsible for 90% of all lung cancers.[2] Heavy smokers, individuals who smoke two or more packs of cigarettes daily, die of lung cancer at a rate 20 times greater than that of non-smokers.[3] Former smokers, after five years of cessation, have relative risks that are lower than those of current smokers, but still higher than those of never smokers.[4] Even non-smokers, when exposed to environmental tobacco smoke, a Class A carcinogen, show a 20% greater risk of lung cancer as compared to individuals without such exposure.[5] Thus, lung cancer is largely a preventable disease.

Methods

Utilizing data from the Missouri Cancer Registry (MCR) for the period 1985-1992, we calculated lung cancer incidence rates by disease diagnosis year. Missouri Center for Health Information Management and Epidemiology (CHIME) death certificate data were used to determine lung cancer mortality rates for the periods 1980-1996 and 1990-1996.

Yearly incidence and mortality rates per 100,000 population were computed by age, gender, race (all, white, and African American), and were age-adjusted by the direct method to the U.S. 1970 standard million population. The annual percent change for incidence and mortality by gender and race, was determined using linear regression of the natural logarithm of the rate.[6] Projected lung cancer mortality rates for the year 2002 were estimated from predicting linear equations of yearly rates.

Missouri lung cancer incidence and mortality rates were compared to the Surveillance, Epidemiology, and End Results (SEER) Program data base of the National Cancer Institute (NCI). The SEER program collects cancer incidence data from nine population-based cancer registries, covering about 10% of the U.S. population.[7]

Results

Lung Cancer Incidence: During 1985-1992, a total of 30,039 lung carcinomas were diagnosed in Missouri. The overall (all genders and races) lung cancer incidence rate during that period (61.9 per 100,000) increased a non-significant 0.7%. African American incidence increased 5.2% (not statistically significant). Missouri's lung cancer incidence rate for individuals under age 65 was 33.1 per 100,000, with significant differences between rates for whites (32.3) and African Americans (40.6 per 100,000) (Table 1). Among Missourians over age 65, African Americans had lower lung cancer incidence at 298.7

Continued on page 58

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Table 1. 1985-1992 Period Incidence of Lung Cancer by Race, Sex and Age: Missouri

Age	All Races			Whites			African American		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
All	61.9	90.0	41.3	61.2	88.8	40.6	66.1	95.8	45.8
Below 65	33.1	42.4	24.7	32.3	41.3	24.1	40.6	53.8	30.4
65 and above	325.3	524.8	192.6	324.5	523.1	191.7	298.7	479.7	227.2

Missouri Cancer Registry - rates are per 100,000, age adjusted and standardized to the 1970 US population.
Population estimates - DOH Center for Health Information Management and Epidemiology

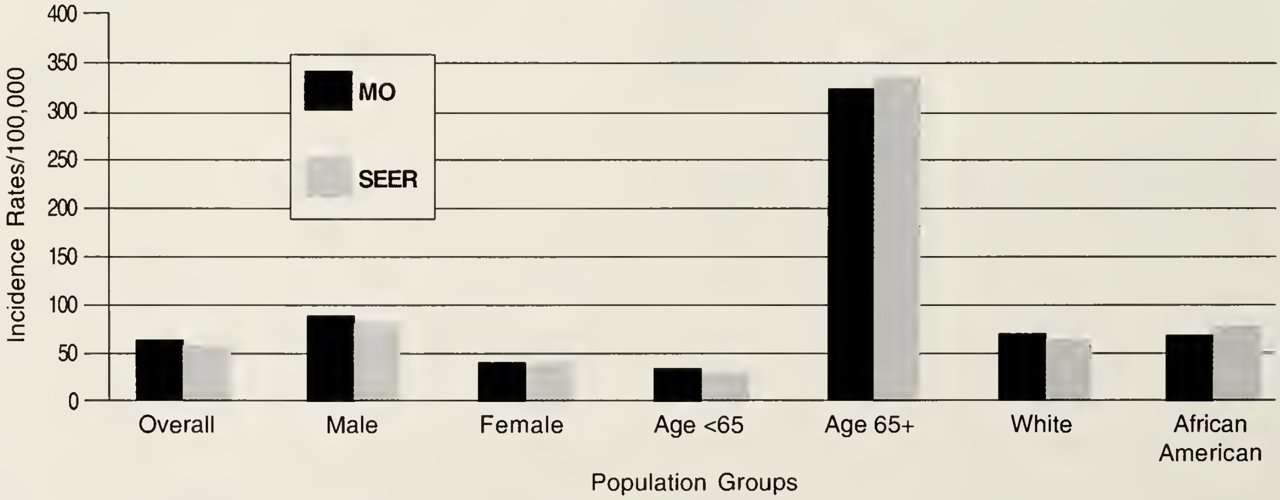
versus 324.5 per 100,000 for whites. Missouri's lung cancer incidence surpassed national SEER rates for all individuals under age 65, except for African Americans (Figure 1). Missouri counties with the highest incidence rates included Wayne (100.7), Pike (96.5), and Benton (92.9) compared to the state rate of 61.9 per 100,000 (not in tables).

Lung Cancer Mortality: During 1980-1996, 55,093 Missourians died from lung cancer. In that 17 year period, Missouri's overall lung cancer mortality rate increased 25% (p=.0001), due primarily to a 63.4% increase (p=.0001) in deaths among women. The rate for males increased 5.8% (p=.04) (Table 2). Among African Americans, the mortality rate (67.4) was 32% greater than that of whites (51.2 per 100,000). Counties with the highest lung cancer mortality rates include Madison (74.4), Mississippi (73.3), Dunklin (71.6), Benton (71.3), and Carter (70.2) compared to the state rate of 52.4 per 100,000 (not in tables).

For individuals under age 65, Missouri's lung cancer mortality was 25.0 per 100,000, with the greatest difference (52%) between rates for whites (24.1) and African Americans (36.6 per 100,000) (not in tables). Among Missourians over age 65, the African Americans mortality rate is 349.3 versus 298.3 per 100,000 for whites.

In comparison, during the 1990-1996 period, overall lung cancer mortality increased 1.1% (not statistically significant), with the largest increase among white women (17.5%, p=.01) and the greatest decline seen in African American men (-27.8%, p=.002). Missouri rates exceed those nationally for each group by race, age and gender (Figure 2).

Figure 1. Lung Cancer Incidence, Missouri (1985-1992)[1] vs. SEER (1988-1992)[2]



[1] Missouri Cancer Registry - rates are per 100,000, age adjusted and standardized to the 1970 US population.
Population estimates - DOH Center for Health Information Management and Epidemiology
[2] Surveillance, Epidemiology and End Results (SEER) Program, National Cancer Institute, 1997
8/98

Discussion

Our results show that while overall lung cancer incidence rose only 0.7% from 1985-1992, there were slight, but statistically significant reductions in the rates for males, and great increases in women's rates, especially among African Americans. Missouri's lung cancer incidence rates for individuals over age 65 were significantly lower than national rates for females and African Americans.

Missouri lung cancer mortality increased substantially during 1980-1996, however, analysis of 1990-1996 rates show that those large increases have probably reached their peak. Comparing Missouri rates with those of SEER reveals that Missouri's trends in lung cancer mirror those of the U.S., with significantly increasing death rates during 1973-1990, followed by significantly decreasing death rates after 1990.[8] However, even with these marked declines, analysis of 1990-1996 Missouri lung cancer mortality rates show a 17% rise among white women and smaller increases among whites and the overall total. Lung cancer mortality in Missouri exceeds national rates by race, age and gender. Missouri ranks 11th in lung cancer mortality, compared to other states.[9]

Despite the fact that the proportion of smokers has dropped since the mid-1960s, the incidence of lung cancer is expected to continue to rise through the year 2002, especially among women, because of the long latency period between initiation of smoking and onset of the disease.[10] Estimated projections in lung cancer mortality also show rate decreases for Missouri males and African Americans over the next five years.

The incidence and mortality data reported here are limited by completeness of reporting. State law

Continued on page 60

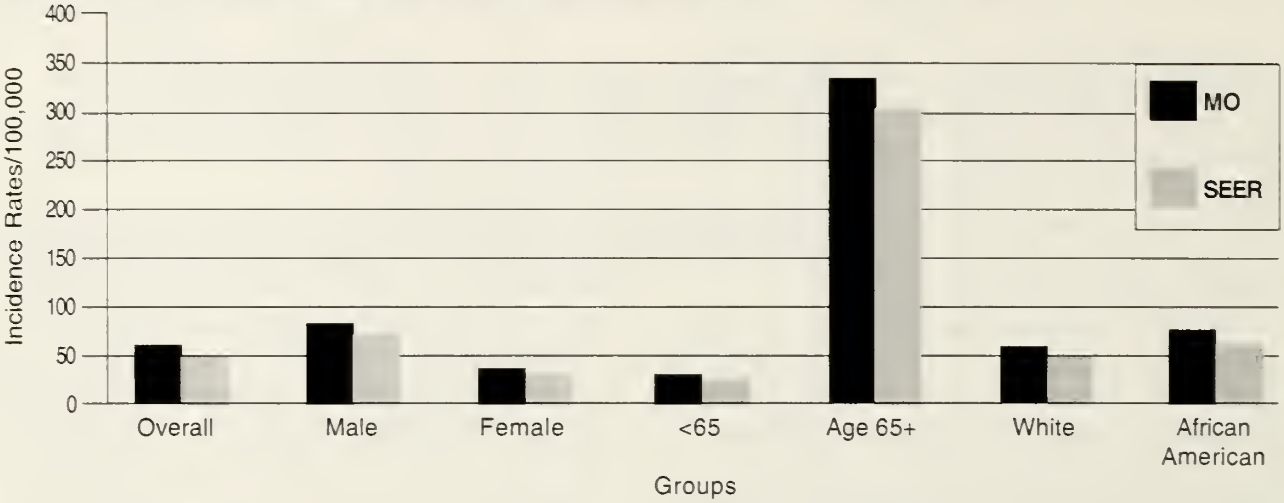
Table 2. Missouri Age Adjusted Lung Cancer Mortality Rates, Period Percent Changes, and Year 2002 Rate Projections

Race	Gender	1980-1996 Mortality Rate	1980-1996 Period % Change	1990-1996 Mortality Rate	1990-1996 Period % Change	Projected Yr. 2002 Rate
All	Total	52.4	+ 24.9 (p=.0001)	56.2	+ 1.1	57.0
All	Female	30.5	+ 63.4 (p=.0001)	35.9	+ 15.1 (p=.02)	42.7
All	Male	82.3	+ 5.8 (p=.04)	83.7	- 7.3	75.9
White	Total	51.2	+ 25.3 p=.0001)	55.0	+ 3.6	57.6
White	Female	30.0	+ 63.9 (p=.0001)	35.3	+ 17.5 (p=.01)	43.1
White	Male	80.0	+ 5.6 (p=.03)	81.5	- 4.7	76.6
African American	Total	67.4	+ 24.2 (p=.002)	72.9	- 18.4 (p=.05)	55.7
African American	Female	37.2	+ 62.8 (p=.0001)	44.3	+ 0.2	44.0
African American	Male	111.3	+ 9.8	115.2	- 27.8 (p=.002)	73.4

Rates are per 100,000, age adjusted and standardized to the 1970 US population
Population estimates by year-DOH Center for Health Information Management and Epidemiology
Year 2000 & 2002 projected rates based on 1990-1996 annual percent change

Continued from page 59

Figure 2. Lung Cancer Mortality Rates, Missouri (1990-1996)[1] vs. SEER (1990-1994)[2]



[1] Missouri Cancer Registry - rates are per 100,000, age adjusted and standardized to the 1970 US population. Population estimates - DOH Center for Health Information Management and Epidemiology
[2] Surveillance, Epidemiology and End Results (SEER) Program, National Cancer Institute, 1997

requires reporting by hospitals, but more and more cancer cases are being diagnosed in other non-hospital sites.

Previous reports of Missouri lung cancer mortality found that rates in women increased 377% from the 1950s to the 1980s, while the rates in men increased 169%.[11] Our analysis of data (1980-1996 and 1990-1996) show that we are still seeing increases in lung cancer deaths, albeit at a lower level, especially among women.

Of increasing concern, however, is the rate of lung cancer 20-30 years in the future. Missouri adult smoking rates were stable from 1986-1995, but have increased each year since then to the current smoking prevalence of 28.6% (1997).[12] The smoking rate among Missouri high school students is 40.3% (1997).[13] Currently, Missouri has the 2nd highest smoking rate in the country for adults and ranks 5th for high school students.[14,15] Unless efforts are taken to substantially prevent and reduce smoking levels, each year thousands of Missourians will be dying an average of 13 years prematurely from lung cancer and other smoking-attributable diseases.[16]

Some ways to reduce the prevalence of tobacco use include enforcing laws prohibiting sales to minors, requiring proof-of-age when selling tobacco products, and raising prices through substantial increases in tobacco excise taxes.[17] Physicians can take a strong leadership role regarding tobacco prevention and control by screening all patients for tobacco use at every visit, actively promoting cessation for patients who smoke, and supporting community efforts to reduce second hand tobacco smoke exposure. MoMed

About the Authors

The authors are with the Missouri Department of Health, Division of Chronic Disease Prevention and Health Promotion. Additionally, Dr. Simoes is Adjunct Professor at the University of Missouri Medical School, Family and Community Health Department, and Assistant Professor at the St. Louis University, School of Public Health.

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Salmonella Outbreaks in the Kansas City Metropolitan Area: Varying Presentations

Tiffany H. Wilkinson, MPH; Ron G. Griffin, MPH; Andrew A. Warlen, BS;
Michael Hershley, BS and Gerald L. Hoff, PhD

Abstract

Four outbreaks of *Salmonella* in the Kansas City metropolitan area between 1996 and 1998 are used to illustrate changes in the epidemiology of foodborne diseases and recognition by public health authorities. Physicians are the critical link in the recognition of foodborne outbreaks, and that linkage is tied directly to their index of suspicion and the appropriate collection and testing of specimens from their patients, as well as notification of the local health department.

Salmonellae are the number two cause of foodborne illnesses in the United States with more than 45,000 reported infections per year or approximately 17 cases per 100,000 population.[1] Approximately, 21% of infected persons are hospitalized.[2] Between 1990 and 1997, an average of 581 cases of salmonellosis have been reported in Missouri each year[3] (Figure 1). In Kansas City, for 1990-1995, there was an annual average of 37 unrelated cases of *Salmonella* infection among residents (8.5 per 100,000 population), with no *Salmonella* outbreaks being recognized since 1988. However, between 1996 and the end of October 1998, Kansas City experienced four unique outbreaks of *Salmonella*. Those outbreaks are described in this report and illustrate the importance of obtaining appropriate specimens from persons who may be experiencing a foodborne illness and, in the case of *Salmonella*, carrying the identification process to the species level.

Outbreaks

Restaurant A: A biphasic outbreak of *Salmonella braenderup* occurred between late August and late October 1996, although recognition of the outbreak did not occur until September 26. Though four of the initial six cases had been reported to the Kansas City Health Department (KCHD), they were reported as *Salmonella* group C and interviews failed to identify any linkages between the cases. It was not until the Missouri Department of Health (MDOH) serotyped those isolates plus two isolates from yet unreported cases did the outbreak become apparent.

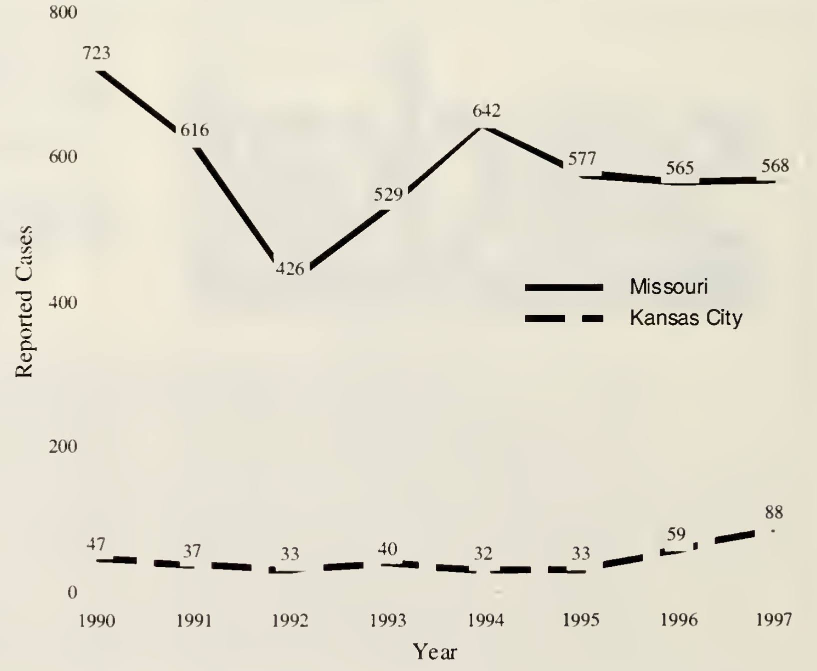

Figure 1. Reported cases of salmonellosis in Missouri and Kansas City, 1990-1997.

S. braenderup is a rarely encountered serotype in Missouri. Between 1980 and 1995, only six cases had been reported in Kansas City, and in 1995, only eight cases were reported statewide. At this point, KCHD notified all hospitals and laboratories on both sides of the state line about the situation and requested that all group C isolates of *Salmonella* be forwarded to MDOH for serotyping. Additional cases began to be identified and interviews suggested that restaurant A may have been the source of the infections.

Over the 55 day period of the outbreak, KCHD identified 37 symptomatic cases among patrons and nine asymptomatic cases among the food handlers (seven cases) and their families (two cases). Thirty individuals (81%) sought medical care from their physician or an emergency department; 16 were hospitalized of whom two were thought to have appendicitis and underwent appendectomies.

All *Salmonella* isolates were serotyped by MDOH. Eighteen isolates from employees, patrons, and two persons who denied eating at the restaurant were submitted to the Minnesota Department of Health for pulsed field gel electrophoresis (PFGE) analysis; they all had the same PFGE pattern, BR5.

A 47th case having the BR5 strain was discovered by KCHD on June 6, 1997. This individual was a frequent patron of Restaurant A and both he and his roommate had intermittent episodes of diarrhea extending as far back as the original outbreak. Due to questionable hygienic practices it was hypothesized the *S. braenderup* infection had been acquired during the initial outbreak and maintained between these two individuals. However, as a precaution, all the restaurant staff were again tested for *Salmonella* and none were found to be infected.

The investigation failed to identify any probable food source or any association with a particular food handler. The recognized cases tended to occur singly as well as sporadically. All food and environmental specimens tested did not yield *Salmonella*.

The last KCHD inspection of the restaurant prior to the recognition of the outbreak was on August 28, 1996; the establishment received a score of 66 out of a possible 100. Furthermore, the inspection history of Restaurant A showed continued problems with potentially hazardous foods being out of temperature, poor hygienic practices, improper dish washing sanitizing solution concentrations, and improper chemical storage. Several of these problems again were noted during an inspection on October 4, but did not reoccur during six other inspections conducted through January 7, 1997.

Restaurant B: This was a classical point-source outbreak of *S. agona* associated with catered and eat-in/carry-out food from Restaurant B on April 19, 1997. The investigation into this outbreak was initiated on the basis of four complaints received on April 21 by KCHD from four different families and each family having multiple cases. Eventually, 108 infections were documented, including five among the staff of Restaurant B. Forty-four (44%) of the primary cases sought medical care from their physician or an emergency department; five were hospitalized.

As with the investigation of Restaurant A, hospitals and laboratories in the metropolitan area were notified of the outbreak and asked to ensure that all *Salmonella* group B isolates were submitted to MDOH for typing. Fifteen isolates subsequently were submitted to the Minnesota Department of Health for PFGE typing and all were type SA8. These 15 isolates were from employees, persons at catered events, and persons who ate-in or carried-out food from the restaurant.

While food histories implicated baked beans as the most probable source for the *Salmonella*, no beans were available for testing. In fact, the histories suggested that the contaminated beans were from a two hour time period on April 19. KCHD conducted a detailed review of the bean preparation process that revealed several deficiencies. The beans were put in 10 gallon pans which were then placed within the 450^{0}F smoking oven and left to warm without stirring. The restaurant's decision as to whether the beans were sufficiently hot was subjective, generally bubbling on the edges. When thermometer readings were taken by KCHD from different parts of the pans of beans in the smoking oven, it was revealed that the temperatures within a pan were very inconsistent and rarely reached 140^{0}F. In addition, it was discovered that the uncovered pans of beans were being placed directly under the meat and

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poultry being smoked in the oven, thereby allowing meat drippings to fall into the beans. This practice was halted and an oven dedicated to bean preparation was purchased.

The last routine inspection of Restaurant B was on November 20, 1996, and the establishment received a score of 82. There were two major violations: potentially hazardous foods not being maintained within proper temperature requirements, and the presence of insects. A routine inspection on April 26, 1997, resulted in a score of 70. Again, there were problems with temperature requirements and insects, as well as deficiencies associated with sanitizing utensils and equipment between different food products.

Community Outbreak A: This was a diffuse community outbreak of *S. infantis* and *S. anatum* that involved 81 recognized cases. Of these cases 63 (78%) were residents of Kansas, 16 (20%) were residents of Missouri including eight from Kansas City, and one resident each from Oklahoma and Minnesota.[4] Onset of illnesses ranged from February 19 through May 26, 1997. Seventeen (27%) cases were hospitalized.

During the first week of April, KCHD began receiving a number of laboratory reports of *S. infantis*. This is a rarely encountered serotype with only ten cases being reported in Kansas City between 1980 and 1996. Geographically, these cases were predominately from northeastern Kansas and, to a lesser degree, the metropolitan Kansas City area. As the majority of cases involved Kansas residents, KCHD notified the Kansas Department of Health and Environment (KDHE) on April 9. The investigation of this outbreak was a cooperative venture between KDHE, KCHD, MDOH, various county health departments, and the Centers for Disease Control and Prevention (CDC), with KDHE being the lead agency.

Traditional analysis of food histories was unproductive. Therefore, a case-control study was conducted, but again yielded no identifiable source. Intensive interviews with eight cases revealed that six had consumed foods containing alfalfa sprouts within three days of onset of symptoms. A second case control study was initiated that showed a non-statistically significant association with consumption of alfalfa sprouts within five days of the onset of illnesses. KDHE was able to associate a single sprout producer with a number of cases. At the growing facility, both *S. infantis* and *S. anatum* were recovered from sprouts and the environment. Sales were halted, restaurants contacted, and within a few weeks no more cases were reported. PFGE testing demonstrated that isolates from cases and sprouts were related. Additionally, the Food and Drug Administration acquired sprout seeds from the same implicated lots that a sprout seed distributor had shipped to the sprout grower. *S. anatum* was recovered indicating that the contamination problem originated with the seeds. Further tracing revealed that all the seeds originated with a single Kansas grower, who sold most of the seeds to farmers as pasture seed.

The growing of the sprouts, their packaging and distribution was essentially a one person operation. The sprouts were sold primarily to delicatessen and speciality food stores throughout the Kansas City metropolitan area and northeastern Kansas.

Community Outbreak B: Between June 28 and August 5, 1998, there was a diffuse community outbreak of 24 confirmed and eight presumptive cases of *S. poona* in the Kansas City metropolitan area. Twenty-six (81%) of the cases sought medical attention from their physician or an emergency department and four individuals were hospitalized. Seventy-eight percent of the cases were Missouri residents (nine lived in Kansas City), and the remainder were residents of Wyandotte and Johnson counties in Kansas. Because of the diffuse nature of the outbreak and the fact that most cases were Missouri residents, MDOH assumed the investigative lead, supported by KCHD and other local health departments.

Recognition of the outbreak was delayed until August 3 by the diffuse nature of the outbreak, the sporadic occurrence of cases, and delays in submitting all isolates for serotyping and PFGE analysis. While PFGE testing by MDOH revealed that the *S. poona* isolates were identical, food histories of cases and household contacts failed to identify any suspect food items or possible sources for the outbreak.

Discussion

The outbreaks of salmonellosis described in this report reflect varying presentations – the classical point source outbreak of *S. agona* occurring at

Restaurant B; a propagated, common-source outbreak of *S. braenderup* involving Restaurant A; and two diffuse geographic outbreaks. Recognition of the *S. braenderup* outbreak at Restaurant A and both of the community wide outbreaks relied on identification of the infecting serotypes, which in turn, happened to be uncommon serotypes for the community. While it is possible that the *S. braenderup* outbreak might have been identified without knowing the serotype, probably neither of the two community outbreaks would have been detected due to the sporadic nature of the cases over time and geography. Unfortunately, diffuse outbreaks of *Salmonella* and other foodborne pathogens are becoming more common.[5] The traditional outbreak scenario, as seen with *S. agona* at Restaurant B, is associated with a high inoculum dose and a high attack rate; whereas the diffuse outbreak scenario, as seen with the *S. infantis/S. anatum* and *S. poona* outbreaks, typically reflects low-level contamination of a widely distributed commercial food product.

It has been estimated that only 1% to 5% of all *Salmonella* infections are reported to health departments.[6] If these estimates are correct, then the 268 individuals identified in the four outbreaks described here were merely a surrogate for the 5,360 to 26,800 affected persons in the Kansas City metropolitan area. Of those who were identified as infected during these outbreaks, 53% sought medical care and 25% of those individuals were hospitalized.

Recognition of a foodborne outbreak starts with the health care provider having a proper index of suspicion and followed by a proper work-up of the patient.[7] Based on the patient's history and clinical symptoms the list of possible etiologies can be narrowed and the appropriate specimens collected for laboratory analysis. Once the initial identification of a pathogen has been made and the local health department notified, quite often further identification of the isolate is necessary for public health purposes. Using *Salmonella* as an example, the isolate needs to be identified to the serotype; this usually requires submission to a reference laboratory such as the state public health laboratory. Quite frequently this does not occur – between 1980 and 1994, only 48% of *Salmonella* isolates from Kansas City were serotyped.[8] The first suspicion of an outbreak may be made by the laboratory based on the frequency of isolations of various serotypes. This was illustrated clearly with three of the outbreaks discussed in this report. An increased number of identifications of *S. braenderup, S. infantis* and *S. poona* in each case suggested that outbreaks may be occurring. In 1997, for example, MDOH had recorded only eight cases of *S. poona* infection statewide.[9] Therefore, the occurrence of 24 seemingly unrelated cases of *S. poona* over a month's time in 1998 in the Kansas City metropolitan area was a clear indication that an outbreak may have occurred. PFGE testing then established the relatedness of the isolates providing further confirmation that this was a true outbreak and not a coincidental constellation of cases.

The epidemiology of foodborne infections in the United States has been altered in recent decades as new pathogens have emerged, the food supply has changed, and the number of persons with heightened susceptibility to foodborne diseases has increased.[10-12] Food items previously thought to be safe are now being considered hazardous. In the summer of 1998, the Food and Drug Administration issued only its third food advisory that persons of certain ages or with certain health conditions should avoid eating a particular food item. That advisory was issued regarding the consumption of raw alfalfa sprouts and the risk of salmonellosis and *Escherichia coli* O157:H7. Additionally, acidic, unpasteurized fruit juices can no longer be considered as safe.[13] Yet, surveys of citizens in this country have found people woefully deficient in their knowledge and practice of safe food handling, preparation and consumption.[14,15] And, while many people and healthcare providers consider foodborne illnesses as little more than short-term problems, it must not be forgotten that 2% to 3% of foodborne illness cases result in chronic sequelae.[16] These sequelae may have a variety of presentations, such as rheumatoid inflammation of joints following *Salmonella* infections or Guillain-Barre syndrome following infection with *Campylobacter*.[17] Also, acute presentations of foodborne illnesses may be mistaken for other health conditions, such as the two cases associated with the *S. braenderup* outbreak from Restaurant A who underwent appendectomies.

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While public health morbidity surveillance in combination with improved laboratory technology, i.e., PFGE, may result in faster recognition of foodborne outbreaks, there still exists a need for public awareness and behavioral changes regarding proper food handling, preparation and storage. And, it cannot be forgotten that physicians are the critical link in the recognition of foodborne outbreaks, novel foodborne pathogens, and new food-pathogens associations; and that linkage is tied directly to their index of suspicion and the appropriate collection and testing of specimens from their patients, as well as notification of the local health department. In this era of managed medical care, the expenses associated with these actions for an individual patient should not take precedence over the physician's obligation to help protect the community's health. **MoMed**

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Urban-rural Differences in Medicare in Missouri

Kazim Sheikh, MD; Claudia Bullock

Abstract

Health Care Financing Administration's (HCFA) administrative data were analyzed to examine urban-rural differences in the characteristics of Medicare beneficiaries, their utilization of medical care, the providers of services, and selected outcomes in Missouri. As compared to the residents of urban areas, the residents of the rural counties were a little poorer, had equal access to health care, and utilized more health care services; but the cost of major services was lower.

Introduction

When first implemented in 1966, the Medicare legislation provided health insurance coverage for most U.S. citizens aged 65 years or over. In 1973, legislation extended coverage to the chronically disabled, most persons with end-stage renal disease, and ineligible persons who elect to buy into the program. Part A of Medicare, also known as hospital insurance, reimburses participating institutional providers for the inpatient hospital, skilled nursing facility, home health, and hospice services. Part B benefits are optional and cover physician services in any location, diagnostic services, selected drugs, medical products and supplies, and remedial therapies.

Although the risk-sharing Medicare contract options for health maintenance organizations (HMOs) were introduced in 1972, there were only five HMOs in the country with such contracts in 1985. Since then, enrollment in HMOs has sharply increased every year. As of May 23, 1998, approximately 16.5% of all Medicare beneficiaries were enrolled in managed care plans. Approximately 15% of Medicare beneficiaries have dual eligibility, that is, they are eligible for Medicare and Medicaid coverage. For most dually eligible beneficiaries, the Medicaid coverage pays for the Part A and B services not covered by Medicare and for various cost-sharing requirements for the covered services.

There are regional, inter-state, and intra-state variations in the HMO coverage and health care utilization both in the managed care and fee-for-service sectors. As expected, there are marked differences between urban and rural areas of the country with respect to the distributions of health care providers and utilization.[1] This paper describes the characteristics of Medicare beneficiaries, their utilization of medical care, the providers of services, and selected outcomes in the calender year 1996 in Missouri.

Methods

HCFA's administrative data were used for this descriptive study. In order to examine urban-rural differences, the Medicare population in Missouri was divided in three groups according to the density of the beneficiary population in the county of residence. Three counties with more than 50,000 Medicare beneficiaries residing in each were arbitrarily regarded as the urban counties. Twelve counties, each having 9,000 to 50,000 beneficiaries living in them, were regarded as the semi-urban counties, and the remaining 100 counties were the rural counties. Of the 883,061 subjects enrolled in Medicare any time during 1996, 329,325 (37.3%) resided in the urban counties, 206,187 (23.4%) resided in semi-urban counties, and the remaining 347,549 (39.4 %) resided in the rural counties.

Dual eligibility was established by matching the Social Security Numbers (SSN) in HCFA's Medicaid Statistical Information System with SSNs in the Medicare Denominator Files and/or indication in the denominator file of the state "buying-in" services covered by Medicare for which the beneficiary could not pay. Since 99% of the Missouri population aged 65 and over were enrolled in Medicare in 1996, the state vital statistics and estimates supplied by the Missouri Department of Health and the U.S. Bureau of Census were used to study the time trends in mortality. The ICD-9-CM codes for diagnoses and procedures were used in the analyses of Part A services utilization and CPT-4 codes for procedures were used in the analysis of Part B services.

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The health care utilization data on the Medicare beneficiaries enrolled in HMOs available to HCFA were incomplete. Consequently, the utilization analyses were restricted to the beneficiaries covered in the fee-for-service (FFS) sector. The measures of utilization were stratified according to the counties of residence of the beneficiaries, not the location where the services were provided. So that, a claim from a provider located in an urban county for services provided to a beneficiary residing in a semi-urban county was counted among the claims for the semi-urban counties. Physicians and other practitioners in Missouri who filed at least one claim which was paid were counted as providers of health care in the Medicare program. Their location was determined by the zip code of the place where the services were performed. Those physicians and practitioners who provided services in more than one county category were counted in each category. Consequently, the total number of providers of specific type in all county categories appear greater than the actual number of providers in 1996 participating in Medicare.

The direct standardization method was used to adjust for age differences between groups. The statistical significance of the differences between proportions and means or averages were tested by the Chi-square test and the t-test respectively.

Beneficiary Population

In 1996, 374,971 males and 508,090 females in Missouri were eligible for Medicare. Of this cohort of 883,061 beneficiaries, 90,966 (10.3 %) were non-white Americans mostly residing in the metropolitan areas, and 68,630 (7.7 %) were enrolled in HMOs. Thirteen percent of the FFS beneficiaries were under the age of 65; they were either chronically disabled or they had end-stage renal disease requiring dialysis or kidney transplant. Medicare beneficiaries aged 65 and over residing in Missouri were a little older than the beneficiary population of the United States in the same age group; the difference between the age distributions is statistically significant ($p<0.001$). The mean ages of the beneficiaries residing in the urban, semi-rural, and rural counties were 72.4, 71.8, and 72.2 years respectively. The differences between the mean ages of beneficiaries residing in the semi-urban counties and those residing in the other counties are statistically significant ($p<0.01$).

In 1996, 15.3% of all Medicare beneficiaries in Missouri were also eligible for Medicaid. The highest proportion of the dually eligible beneficiaries was in the under 65 age group (Figure 1). Among the beneficiaries aged 65 and over, the frequency of dual eligibility increased with age; and in any age group, the percentage of dually eligible beneficiaries was significantly higher in the rural counties than in the other counties ($p<0.05$).

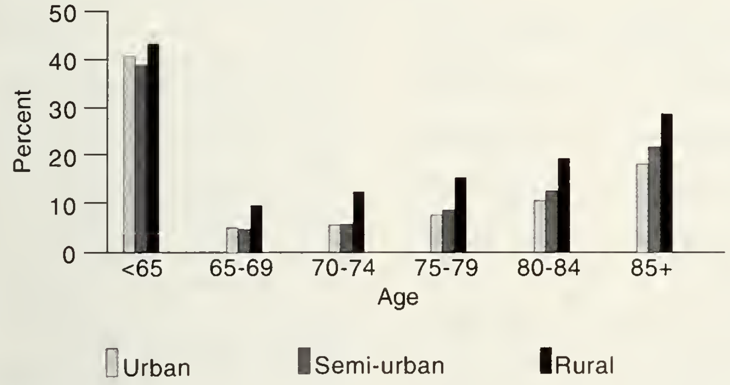
From 1986 to 1996, there was a 10.6% gradual increase in the Medicare beneficiary population of Missouri aged 65 and over. This growth was largely in the semi-urban counties. During the same period, the age-specific mortality in the 65 to 74 and 75 to 84 age groups has decreased

Table 1. Number of health care providers per 100,000 Medicare beneficiaries in Missouri according to the beneficiary population density, 1996

	Counties			
Providers	Urban	Semi-urban	Rural	All
Hospitals*	15.8	16.5	20.4	17.8
Long-term care	45.2	61.1	88.9	66.1
Home health agencies	29.5	27.2	32.8	30.2
Physical medicine and rehabilitation	11.2	12.6	5.5	9.3
Hemodialysis	10.6	9.2	4.9	8.0
Intermediate care & mental retardation facilities	5.2	4.8	5.8	5.3
Rural health clinics	0.0	4.4	44.3	18.5
Hospices	6.7	8.7	10.1	8.5
Other	11.2	6.8	6.3	8.3
All	137.3	154.2	220.1	173.8

*Short-term primary, secondary, and tertiary care hospitals

Figure 1. Age-specific percentage of Medicare beneficiaries who were dually eligible according to the beneficiary population density in the counties in Missouri, 1996



from 28.7 to 26.9 per 1,000 and from 63.8 to 61.4 per 1,000 population respectively. The death rate for the 85 and over age group slightly increased.[2] In 1996, mortality among Medicare beneficiaries in Missouri was 49.1 per 1,000 population. There was no statistically significant difference between the age-adjusted death rates in the urban, semi-urban, and rural counties. The leading causes of death in the elderly population of Missouri were the same as those for the U.S. population — heart disease, cancer, stroke, chronic obstructive pulmonary disease, pneumonia and influenza.[2]

Providers of Health Care

Table 1 shows the numbers of provider facilities in Missouri which participated in Medicare in 1996. The numbers of all providers, hospitals, long-term care facilities, and hospices per 100,000 beneficiaries were higher in the rural counties and lower in the urban counties than those in the semi-urban counties. The trend with respect to hemodialysis units was in the opposite direction, the number being highest in the urban counties and lowest in the rural counties. As expected, most rural health clinics were in the rural counties and none in the urban counties. Altogether, there were 13.8 physicians — general practitioners and specialists — for every 1,000 beneficiaries in Missouri who filed at least one claim in 1996. However, their distribution varied according to the Medicare population density in the state — 19.4, 16.4, and 6.9 per 1,000 beneficiaries in the urban, semi-urban, and rural counties respectively. Except for the general surgeons, there were more specialists in the urban counties and less in the rural counties than the semi-rural counties. The trend for the general practitioners was in the opposite direction, the number being the highest in the rural counties and lowest in the urban counties. The number of independent nurse practitioners per 10,000 beneficiaries was lower in the urban counties as compared to that in the rural and semi-urban counties. Just as the specialist physicians, the number of clinical psychologists was highest in the urban counties and lowest in the rural counties (Detailed data available on request).

Health Care Utilization

As expected, health care utilization in terms of the number of claims for virtually all types of services covered by Medicare increased with age among beneficiaries aged 65 and over (Data available on request). Table 2 shows the age-adjusted number of claims per 100 beneficiaries for major types of services provided in 1996 and the cost of an average claim in relation with the beneficiary population density. The number of claims for inpatient and skilled nursing services were significantly higher in the urban counties than those in other counties. The number of home health agency services, both Part A and B, were higher in the rural counties and lower in the urban counties than those in the semi-urban counties. The trend for all Part B services was in the opposite direction, the highest number of claims being in the urban counties and the lowest in the rural counties. Except for the hospice and all Part B services claims, the cost of an average claim was lowest in the rural counties and highest in the urban counties (Table 2).

Age was also correlated with the number of days in short- or long-stay hospitals for male and female beneficiaries aged 65 and over (Data available on request). On average, male and female beneficiaries stayed 210.7 and 208.1 days per 100 beneficiaries

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Table 2. Age-adjusted number of fee-for-service claims in 1996 per 100 Medicare beneficiaries residing in Missouri and average cost per claim according to the beneficiary population density in the counties of residence

	Counties		
Type of Service	Urban	Semi-urban	Rural
All Part A Services	102.7 ($3,270)	104.2 ($2,797)	105.3 ($2,538)
Inpatient	35.8* $6,935)	33.9 ($6,179)	34.1 ($5,841)
Skilled Nursing	11.0* ($3,443)	10.4 ($3,217)	10.4 ($2,665)
Home Health Agencies (Part A)	52.5* ($864)	56.0 ($729)	57.7* ($607)
Hospice	3.33* ($1,573)	3.91 ($1,674)	2.97 ($1,630)
All Part B Services	1939* ($87)	1829 ($81)	1736* ($81)
Outpatient	291* ($183)	269 ($163)	347* ($140)
Home Health Agencies (Part B)	1.14* ($45)	2.04 ($45)	2.10 ($21)

Costs per claim are given in parentheses

*Significantly different from the number of claims for the same type of service provided in other counties (p<0.01).

respectively in short-stay hospitals and 6.1 and 6.5 days per 100 beneficiaries respectively in long-stay hospitals in 1996 (Table 3). The differences between these averages are not statistically significant. These sex differences for short stays were also apparent in each county category (Table 3). There appeared a significant trend in the number of age-adjusted days male and female beneficiaries stayed at the short-stay or long-stay hospitals, the numbers being highest for the urban counties and lowest for the rural counties.

Table 4 shows the age-adjusted number of acute care hospitalizations in 1996 per 1,000 beneficiaries aged 65 and over due to common primary diagnoses in relation with the beneficiary population density in Missouri. For most diagnoses, the highest number of hospitalizations were for the beneficiaries residing in the rural counties and the lowest in the urban counties. An exception was the hospitalizations due to septicemia for which there was a statistically significant trend in the opposite direction (p<0.001).

FFS claims data on the utilization of three common items of ambulatory care were also analyzed according to the beneficiary population density. In 1996, 33.5 colonoscopy procedures and 44.5 cataract extractions per 1,000 beneficiaries were performed in the entire state of Missouri. Cataract surgery was performed at the rate of 40.1, 46.0, and 47.3 per 1,000 beneficiaries for the residents of the urban, semi-urban, and rural counties respectively. The differences between these rates are statistically significant (p<0.001). However, the frequency of colonoscopy was significantly higher for the residents of semi-urban counties than that for the residents of urban and rural counties. Medicare beneficiaries aged 65 and over covered in FFS accounted for 289,191 emergency room (ER) visits, or 40.8 visits per 100 beneficiaries in 1996. Nearly 43% of these visits were "inpatient", that is, they ended in hospital admission and the ER services were claimed as inpatient services. Claims for the remaining ER visits were submitted as "outpatient" services. Table 5 shows the number of age-adjusted ER visits per 100 beneficiaries according to the beneficiary population density in the county of residence. There was a statistically significant

Table 3. Age-adjusted in-patient hospital days per 100 Medicare beneficiaries aged 65 and over according to sex and county of residence in Missouri, 1996

	Short stay		Long stay	
Counties	Males	Females	Males	Females
Urban	224.5*	223.1*	8.4*	8.4*
Semi-urban	207.4	201.8	5.2	6.7
Rural	202.3	198.4	4.8	4.8
All	210.7	208.1	6.1	6.5

*Significantly greater than hospital days in semi-urban and rural counties, p<0.001

Table 4. Age-adjusted acute care hospitalizations in 1996 due to leading causes per 1,000 Medicare beneficiaries aged 65 and over residing in Missouri in relation with the beneficiary population density in the counties of residence

	Counties		
Diagnosis	Urban	Semi-urban	Rural
Pneumonia and influenza	20.0**	22.1	26.0**
Congestive heart failure	20.9	20.0	21.9**
Cerebrovascular diseases	19.4**	21.2	20.9
Coronary atherosclerosis	13.3**	17.0	17.0
Acute myocardial infarction	9.9**	11.6	12.5*
Chronic obstructive pulmonary disease	9.9**	12.1	12.9
Cardiac dysrhythmia	9.7	9.6	10.1
Osteoarthritis	7.9	8.3	8.2
Fracture neck of femur	9.0	10.1*	9.4
Kidney and urinary tract infection	6.4	5.6*	6.1
Septicemia	7.5**	6.2	5.1**

Asterisks denote significantly different from the number of hospitalizations for the same diagnosis in other counties: * $p<0.05$, ** $p<0.001$

($p<0.001$) trend for "inpatient" ER visits, the highest rate being for the residents of the urban counties and the lowest rate for the rural counties. The trend for "outpatient" ER visits, also statistically significant, was in the opposite direction.

Discussion

The three urban counties included Kansas City and the City of St. Louis. Consequently, the socioeconomic status of the residents of these urban counties was expected to be lower than that of the residents of the semi-urban counties which included the suburbs of St. Louis and Kansas City, and smaller cities. This would explain more frequent screening colonoscopy in the suburbia, and this may also have been a reason for slightly younger beneficiaries living in the semi-urban counties. The need for medical care increases with advancing age, and elderly subjects are expected to move closer to large medical centers with comprehensive diagnostic facilities and a wide variety of speciality and super-speciality services. That seemed to be the pattern in Missouri where the Medicare beneficiary population growth was largely in the semi-urban counties. A relatively higher proportion of Medicare beneficiaries in the rural counties being eligible for Medicaid was an indication of their relatively lower economic status.

It was reassuring to find that the number of general practitioners and independent nurse practitioners serving Medicare beneficiaries was relatively higher in the rural counties. Concentration of specialist physicians in the urban and semi-urban counties is to be expected since advanced diagnostic and therapeutic facilities and academic institutions are concentrated in the regional/ metropolitan centers. However, there were relatively greater number of hospitals (most of small size), long-term care facilities, hospices, and HHAs in relation to the number of beneficiaries residing in the rural counties. These data suggest that the beneficiaries in the rural counties were most likely to have had equal access to medical care. A relatively greater number of claims from fewer hospices in the urban counties may be due to their larger accommodation and/ or higher turnover.

The number of claims for most of the major services were lower in the rural counties as compared with urban counties. As expected, the average cost of major health care services was relatively lower for the residents of the rural counties. The hospice services are itemized into four categories, each with different rate of reimbursement. It is likely that the criteria used for providing a particular service and the decision making policies vary from hospice to hospice. It may be that the expensive items of service, such as continuous home care, are more frequently provided for the beneficiaries residing in the rural counties. For both male and female beneficiaries residing in the rural counties, the number of days in short and long stay hospitals were greater than those for the residents of

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Table 5. Age-adjusted number of emergency room visits per 100 Medicare beneficiaries residing in Missouri in relation with the beneficiary population density, 1996

Emergency room visits	Counties: Urban	Counties: Semi-urban	Counties: Rural
Outpatient	22.2	23.9	24.1
Inpatient*	18.3	17.7	16.6
All	40.5	41.5	40.8

*Emergency room visits which lead to hospital admission

other counties. The criteria for admitting patients in hospitals and the availability of facilities for close observation and appropriate care of patients outside hospitals would explain the urban-rural differences in diagnosis-specific hospitalizations and the number of inpatient days.

Although the number of ophthalmologists per 1,000 beneficiaries serving in the urban counties were four times the number serving in the rural counties, the rate of cataract extractions among the residents of the rural counties was significantly higher. As expected, many cataract extractions and other surgical and diagnostic procedures on beneficiaries residing in the rural counties were performed in the urban and semi-urban counties. However, it appears that beneficiaries living in the rural counties did not have to travel to the urban counties for emergency services. There was no correlation between the rate of ER visits and the beneficiary population density at the state level. (Correlation matrix or scatter available on request). Evidently, the inverse association between "outpatient" ER visits and the beneficiary population density may not be peculiar to Missouri. A similar study of Medicare in the State of Kansas[3] showed similar results. Apart from the beneficiaries' age and health status, many factors could influence the frequency of "outpatient" ER visitation. The beneficiaries' health care utilization behavior and health care providers' business practices may be the main factors. Beneficiaries living in the rural counties may have visited ERs more frequently because of certain personal, family, cultural and socioeconomic reasons. For example, beneficiaries in the rural areas may be working during office hours, or they may not have transport to visit primary care physicians' offices, and visit ERs for minor ailments after office hours. The residents of the rural counties are more likely to put off primary care due to cost and transportation difficulties[4] which may result in ER visits. Lower socioeconomic status has been known to be associated with improper or greater utilization of health care services.[5,6] It is possible that the primary care and family physicians work in ERs in the rural counties. They may have instructed their patients to see them in ERs rather than in their private offices. The hospitals in or near rural counties may also have promoted ER attendance by offering incentives to physicians and patients. In 1994, Medicare allowed $50.30 for an average claim for doctor's office visit, and the average cost of an ER visit in the hospitals participating in Medicare was $97.30.[1] If this cost differential exists in Missouri, there may be an opportunity for cost saving by reducing the rate of unnecessary "outpatient" ER visits. Interestingly, the trend in ER visits which lead to hospital admissions ("inpatient") was in the opposite direction — the highest rate for the residents of the urban counties (Table 5). This finding may be explained by the differences in the procedures for emergency admission to hospital. It may be that emergency admissions in the urban areas are more likely to be via ERs, and emergencies in the rural counties may be directly admitted for inpatient care. Further analysis of ER data by diagnosis may also explain these urban-rural differences.

Selected few measures of health care utilization in 1996 were used in this study to demonstrate urban-rural differences. The results suggest that Medicare beneficiaries who resided in the rural counties were a little poorer than other beneficiaries in Missouri; that they had equal, if not greater, access to hospitals and physicians participating in Medicare; and that with a few exceptions, their utilization of health care was relatively greater; but the cost of major services was relatively lower. These findings are consistent with those of similar studies of other populations.[3,4,7] Although ER and doctor's office visits are largely initiated by the patient or his/her relatives, hospital admission, surgery, other therapeutic and diagnostic procedures, and to some extent, outpatient attendance are determined by the attending physicians. Consequently, the beneficiaries are not entirely responsible for over or under use of these health care services. Different criteria for admitting patients in hospitals and for performing therapeutic and diagnostic procedures in different areas may have contributed to the observed urban-rural differences in health care utilization. In future studies, multivariate analyses of the data should be used to identify the factors independently affecting the utilization of health care in Missouri. Furthermore, data for several years should be analyzed to study time trends which may provide information useful for health care planning and policy decisions. MoMed

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Charles E. Workman, MD, 74, Mission, KS, died August 3, 1998. Dr. Workman, an orthopedic surgeon, helped develop the 911 emergency response system. He was a member of the Missouri State Medical Association.

Robert C. Richart, MD, 75, Kansas City, died November 24, 1998. Dr. Richart was a pathologist and a member of the Missouri State Medical Association.

David L. Beato, MD, 69, St. Louis, died December 15, 1998. Dr. Beato practiced internal medicine and was a member of the Missouri State Medical Association.

Jean B. Willoughby, MD, 84, Prairie Village, KS, died December 21, 1998. Dr. Willoughby practiced internal medicine and was a member of the Missouri State Medical Association.

Henry Schwartz, MD, 89, St. Louis, died December 24, 1998. Dr. Schwartz was a neurosurgeon and taught at Washington University in St. Louis. He was a member of the Missouri State Medical Association.

Erin Dillard, MD, 76, Springfield, died January 9, 1999. Dr. Dillard was an orthopedic surgeon and a member of the Missouri State Medical Association.

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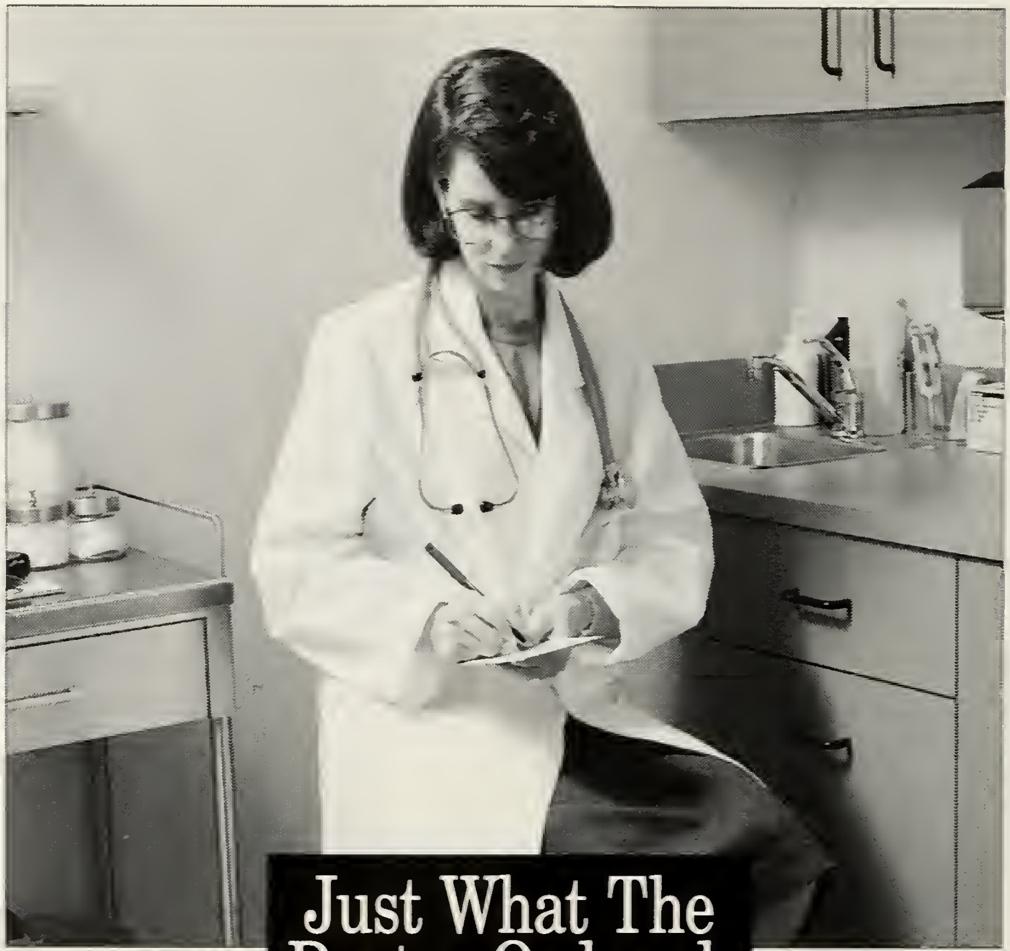

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On the Cover: "Nashville Tree Mist" - by Henry Domke, MD. This started as a black and white photograph Dr. Domke's father, Herbert Domke, took 40 years ago. Dr. Domke digitized the image, then using Photoshop and Painter added the color as he imagined it and softened some elements to add to the mist quality. Dr. Domke's art can be seen at Legacy Art, 1010 East Broadway in downtown Columbia or on their website: legacyart.com. Seventeen of Dr. Domke's digital paintings are in a show until July 1999, on the second floor of the Buttonwood Building in Columbia. Call 573-886-8900 for more information or directions. The show is open Monday-Friday, 9 a.m.-5 p.m.

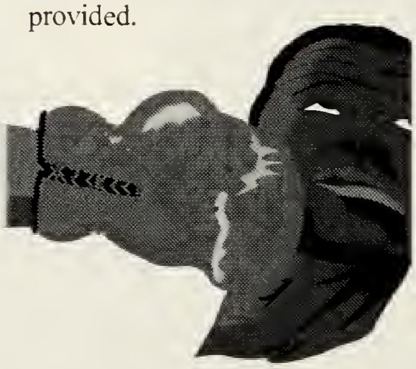
Boxing and the Fight to Ban It

J. Regan Thomas, MD

This past month, an unfortunate situation occurred which brought the world of professional sports into confrontation with the profession of medicine. A Mexican boxer named Fernando Ibarra was injured in a professional boxing match in St. Louis. Ibarra collapsed after loosing the match and required neurosurgical treatment. At the time of this column, he remained comatose and on life support with an uncertain prognosis. He is now literally fighting for his life.

Mr. Ibarra's care was provided by Dr. Kenneth Smith's neurosurgery team at St. Louis University Hospital. Dr. Smith has long been an outspoken critic of boxing and has worked through the MSMA and AMA to have it banned. This recent tragedy has rekindled the controversy and Dr. Smith has been at the forefront of the anti-boxing commentary. He was quoted in the press as saying, "The human brain is the most magnificent organ that has ever evolved, that God has created. The sole object of boxing is to bruise somebody's brain. How can anybody support this?" He was also quoted as pointing out, "We can have a referendum to end cock fighting, but we have people out here beating each other's brains out. It's just despicable."

Because of Dr. Smith's long history of interest in this area and his attempts at effecting a change through organized medicine, I asked him to provide *Missouri Medicine* with further insights into his feelings as a physician about boxing. Here are some excerpts from the material he provided.



"Proponents claim that the sport requires rigorous training, strict discipline, tolerance to pain, resolution, alertness, courage and endurance. These are desirable qualities that may contribute to the physicial and social development of youth. Furthermore, boxing has been proposed as a controlled outlet for aggressive human instincts. Under properly controlled and supervised circumstances, proponents claim the risk of serious head injuries is not greater than for other collision sports.

Opponents of boxing use the adjectives, suicidal, brutal and murderous to describe action in the sport, and further point out that it is the only sport in which, within the rules, each contestant deliberately tries to inflict severe injury on his opponent and render him senseless through a knockout blow. Accordingly, they claim boxing to be morally indefensible. They further state that no present equipment can completely protect the brain from short- or long-term injury. The benefits and intangible values attributed to boxing can be derived, as well, from other less dangerous individual sports."

A variety of reasons no doubt make young athletes pursue a career in boxing. All of them of course know they are putting themselves at risk. This bout was a sanctioned event that followed all the rules and regulations. As physicians who treat the participants in this unique sport, Dr. Smith and his colleagues have a unique insight into the untoward and negative repercussions of this activity. An insight that the rest of us viewers or fans may not be fulling appreciating. It is an interesting controversy that puts phsycians in a fight to protect those who may not fully comprehend or realize they need to be protected. Controversial social and societal issues are always a tough fight. MoMed

Congratulations

Dear Sir:

I wanted to congratulate whoever is writing the *Legislative Report* this year. I have been reading these reports for many years, and certainly this year the humor has enlivened the report considerably. It makes a much better read with a touch of humor here and there. Again, my congratulations to the editor of the *Legislative Report.*

I see nothing wrong with being partisan in our reports, and stating exactly how we feel. I think the *Legislative Report* does an excellent job of that this year, and again, my congratulations.

Sincerely yours.

T. Keith Grebe, MD

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Proposed MSMA Constitution/Bylaws Changes

The following proposed changes in the MSMA Constitution and Bylaws were presented at the 1998 Annual Convention and will be voted on during the 1999 Annual Convention at the First House of Delegates. In accordance with the MSMA Constitution, these proposed changes must be published twice before being voted on. The bracketed items are deleted and the underlined items are added.

Article IX. Funds, Expenses and Budget
[Funds shall be raised by a per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised in any other manner approved by the House of Delegates.] The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

MSMA Bylaws

Chapter XIII. Dues and Assessments
Section 1. (a) The annual dues of this Association shall be set by the Council and payable by January 1 of the year for which they are levied. [$300, which shall be applicable to each active member of the Association beginning in 1987 and shall be levied per capita on the active members of the component societies; physicians leaving training programs and entering practice for the first time shall be assessed dues of $150 for the first calendar year and shall be Active members; physicians entering their second year of practice shall be assessed dues of $225 for the calendar year and shall be Active members; the per capita levy for Resident members shall be $20 per year; Student members shall be assessed dues of $5 per year; Honor members shall not be required to pay dues. Dues shall be payable on January 1 of the year for which they are levied. Those members who join after July 1 of any given year shall be assessed at one-half of their regular dues rate, outlined in this section for the calendar year in which they join.]

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Listening to Physicians: Two Programs to Serve and Increase Our Membership

Stephen Vilmer, MD

Doctors are our lifeblood! Every MSMA member knows this and it is especially important to me as President of your Association. During the January Council Meeting, the latest reports showed slight increases in membership, and there are a few more members than last year at this time.

Responding to our members' needs, many MSMA programs, benefits, and services have been improved. Now, two new programs are developing that will have benefits in two areas, *again, as directed by our members.*

Public Education Campaign on Managed Care Rights

According to the MSMA survey conducted in 1997, enhancing the image of physicians and educating the public on health issues ranked number six and eight, respectively, in importance of MSMA's activities. With this in mind, two of your committees (the Commission on Public Affairs and the MSMA Committee on Governance and Membership) worked together to create a public education campaign on managed care rights. This public education campaign will meet the expectations of MSMA members – enhancing the image of physicians by positioning them as experts on the patient's rights under managed care; and educating the patient on how to control their own health care delivery.

MSMA will fund the $102,000 effort. The six-month long campaign will include a public education brochure, a radio campaign featuring 7,856 thirty-second spots, 14 outdoor billboards placed around the state, radio talk shows featuring MSMA physicians, and MSMA's website distributing the information on managed care rights.

Through this campaign, the value of MSMA membership will be illustrated to physicians as MSMA stands as the defender of the patient-physician relationship. We are asking our members to keep the educational pamphlets in their reception areas. Then, when patients ask about their rights, our members will have easy-to-read information available. Members will receive these pamphlets free, and in April we will alert members to prepare for the campaign.

Patients will be encouraged to ask about their rights through the radio spots and the outdoor boards. The text might include: *"Do you know your rights under managed care? Ask your physician. Brought to you by the Missouri State Medical Association."* Placement of the outdoor boards will be strategic in the six major metropolitan areas of Missouri.

The messages for the radio spots will change weekly or monthly, emphasizing a particular right under managed care. MSMA is also buying time on MissouriNet, a news program that hits more than 250 radio stations across the state on the hour every day.

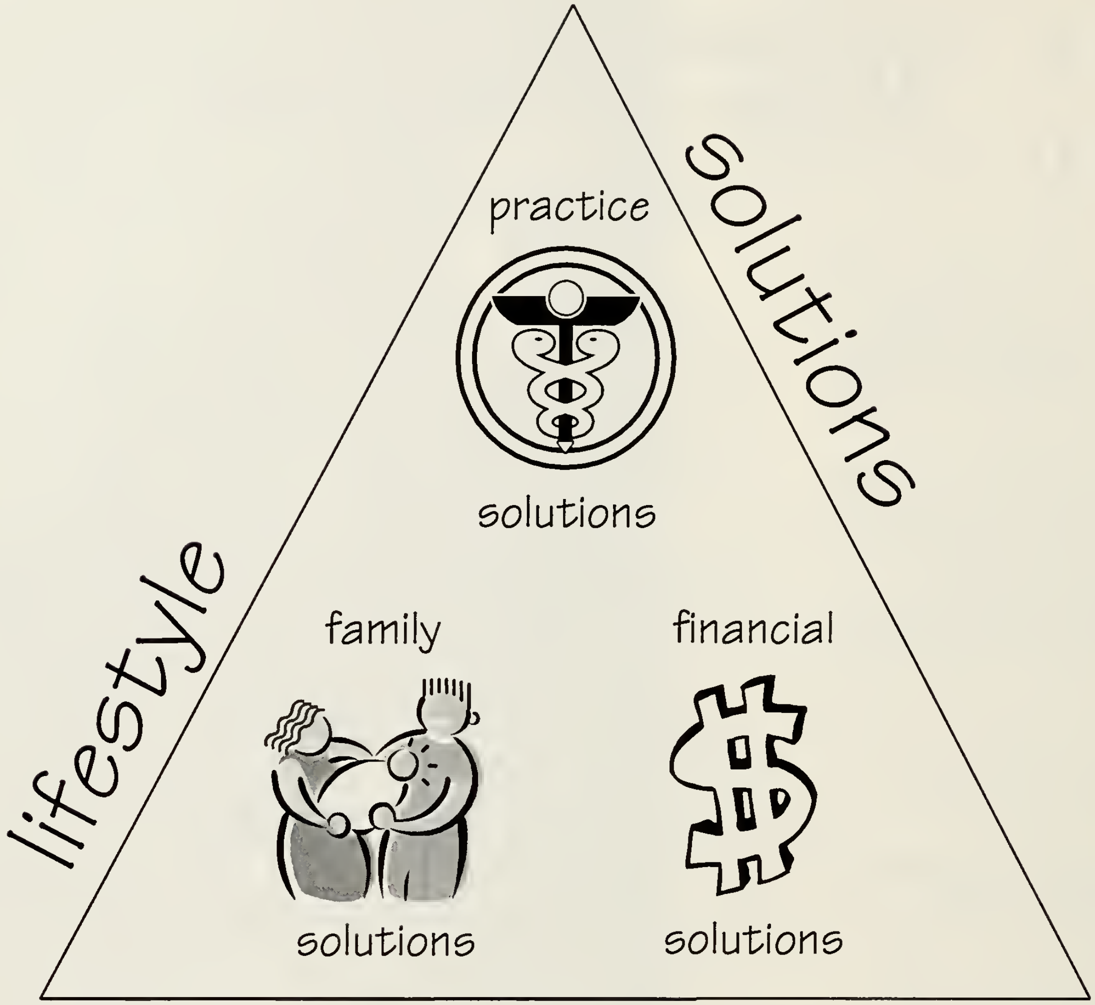
Operation House Call

The second project that MSMA will introduce this year comes from a recommendation of the Membership and Governance Committee. "Operation House Call" will consist of many town hall-style meetings held in conjunction with meetings of MSMA's Component Medical Societies during the months of May and June 1999.

The goal of this program is to increase membership by developing strategies more in tune with the expectations of Association members; and those of nonmembers, too. At these meetings, MSMA will have various incentives to increase participation and, ultimately membership. Suggestions from participants will be taken back to the Council for consideration. In some cases, the participants may find that MSMA already has a solution to their problem. They just need to join! Either way, we will garner the support of members and nonmembers alike.

Why am I telling you this now? Be on the lookout! Watch for the information on the public education campaign. Place the pamphlets in your office. Keep an eye out for an MSMA town hall meeting and *bring a nonmember!*

PROVIDING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Y2K: Missouri Physicians Can Be Prepared

Eugene R. Worth, MD, MEd

Introduction and Overview

The "Year 2000 bug," known more colloquially as "Y2K," is probably familiar to most of the readership, however there may be some readers who are not aware of the scope of this problem. Many early software programs and computer chips (circa 1960s) used a six digit date representation, for example 01-01-99 represents January 1, 1999. Computer designers have used the year 1900 as the current century date for many years, hence the Y2K bug will arise on January 1, 2000, because any two-digit year ending in "00" will be interpreted as "1900." So, what's all the fuss?

Business software computations (credit card expiration dates, banking transactions, Social Security benefits, and more) use calculated, precise dates for interpretation. Y2K will affect all industry sectors throughout the world. Yes, the millenium bug will also affect the health care industry, and probably will affect computers in Missouri physician offices. Software and hardware problems can, and will, occur at any level within the health care industry. Beyond concerns that a computer system will simply not start on January 1, 2000, there are embedded chips in medical equipment, such as ventilators, infusion pumps, and more. Some embedded chips also depend on precise dates, and the problem is compounded when the manufacturers cannot, with certainty, guarantee that embedded chips in their products are free from this bug.

Although the foregoing is theoretical, Y2K will affect the hospital or health care facility in which you practice. As a good manager, I will assume that these health care facilities are vigorously testing and correcting machines that will fail due to Y2K difficulties. Now, let's focus on your practice.

Affecting Missouri Physicians

If you use a personal computer (PC) in your practice, you must check its Y2K compliance. Processors at the Pentium 100 MHz level or slower may be affected by the problem. The processor speed is not part of the problem, but most processors produced in that era are found on mainboards that are non-compliant. Computers coming from the manufacturer with Windows 95 pre-installed, and all computers running Windows 98 or Windows NT 4.0, will not be affected, or have minimal issues.

Thinking that you can just set the clock manually does not solve Y2K, since most computers run on three internal clocks: a real time clock (RTC), Basic Input/Output System (BIOS) clock, and a system clock. All of these clocks are interrelated, thus changing the system clock will not change the BIOS clock the next time the computer is started. Further, if you use a software billing and scheduling program that relies on precise time, and you do not correct for Y2K, then those functions will become highly unpredictable, or, more likely, fail altogether!

Recent repair estimates show that many industries will have their core computer systems repaired before the new millenium begins. Computer consultants are turning to private, small businesses, as many will not make appropriate repairs in time. It is this concern that prompts such an article for Missouri physicians.

Testing for the Y2K Bug

There are several ways to test a computer for Y2K compatibility. Internet users can find a host of testing utilities available. Most of these utilities are free when used in the diagnostic mode, but keep in mind that computer programmers are using the Y2K bug to enhance their livelihood. Ziff-Davis Journals (http://www.zdjournals.com/zdnetpit/int9914.htm) provides three simple tests that you can perform on your computer. Two caveats before performing these tests: close all software programs and, if the computer is on a network, disconnect it from the net

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work. Some network utilities will correct system clocks at startup.

The DOS test: First, make a DOS diskette that has the system installed on it (i.e., the diskette can boot the computer). To make a bootable floppy disk, insert a blank floppy disk into the drive. Then, from a DOS prompt, type the following command: 'format a: /s', being sure you type only the characters inside the tick marks.

After formatting the floppy disk, leave this disk in the floppy drive, shutdown the computer, and restart it. Type '*date*' at the command prompt and change the date to December 31, 1999. Then, type '*time*' at the command prompt and change the time to 11:58PM. Next, shut off your system for at least two minutes, and restart it. Remember to leave the DOS diskette in the floppy drive when you restart the computer. At the command prompt, type '*date*' — if the year is not '2000' then you need to upgrade your computer BIOS chip. When you have successfully completed this test, remember to use the *date* and *time* commands to reset the computer clock to the current date and time.

Some newer computer systems have BIOS settings that bypass the floppy drive on boot-up, booting from the primary hard disk at all times. If this happens, then proceed to the next test. If you are comfortable using the BIOS setup utility, you can change the boot sequence to include the floppy drive, but using the next test will be easier.

The BIOS setup test: You may need to refer to your PC's documentation to figure out how to enter the system BIOS setup utility. On many computers, there is a message at the bottom of the screen that appears just after the Power On Self-Test (POST), reading something like "For SETUP, press <F2>." Pressing this key as soon as you see the message will put you into the BIOS setup utility. The only thing you will change in the BIOS setup utility is the date and time. *Warning!* If you snoop around and change other settings, it is possible to corrupt your hard disk drive(s), so only change the date and time.

Change the system date to December 31, 1999 and the time to 11:58PM, then exit the BIOS setup and save the changes. Next, shut down the system for at least two minutes. The next time you start the computer, press the key(s) required to enter the system BIOS setup program and check the date. If the year is '2000' then your computer has a Y2K compliant BIOS. Again, once you have determined the Y2K reliability of this computer, remember to set the current date and time, save the changes and exit the BIOS setup utility.

The Windows® 95 test: The preceding two tests are the most reliable at determining Y2K compliance. The Windows® 95 test can be flawed, hence the recommendation to use it only if you cannot perform either of the other tests. From the Windows® 95 Start Menu, select Settings|Control Panel. Then choose the Date|Time icon. Change the date to December 31, 1999 and the time to 11:58PM,

Internet Site Name	URL
Year2000 Information Center	http://www.year2000.com/
Ziff-Davis Net — Y2K	http://www.zdnet.com/zdy2k/
U.S. Government Y2K site	http://www.y2k.gov
Microsoft Y2K site	http://www.microsoft.com/technet/topics/year2k/default.htm
Compaq Computer	http://www.compaq.com/year2000/
Dell Computer	http://www.dell.com/year2000/
Gateway Computer	http://www.gateway.com/frameset2.asp?s=corp&p=support&a=&url=/corp/y2k/y2k/default.html
Micron Computer	http://www.micron.com/yr2000/
Medical Devices Y2K site	http://www.show.scot.nhs.uk/y2k/2000/meddevic/index.htm

then close this window and shut down your computer. After a two minute wait, restart the computer and re-open the Date|Time properties box. If the year does not read '2000,' then the computer needs to be upgraded.

My Computer Failed, What Now?

If a computer fails the Y2K compliance tests above, you have three options. First, you can do nothing at all. If this computer is used in your practice, there may be legal ramifications from such a myopic decision. Consumer advocates have sued grocery stores because a scanner failed to recognize a credit card with expiration date of '00.' Therefore, all public businesses, including physician offices, should therefore be warned that consumers will seek legal redress for Y2K difficulties.

Your second option is to fix the problem. Computer manufacturers and operating systems companies have Internet sites detailing procedures you should follow. Another acceptable solution is to hire a computer consultant to rectify the problem. Expect such repairs to total several hundred dollars per machine for the hardware upgrade. Operating system upgrades can also run several hundred dollars per computer, since software companies are not patching older software. Also, choosing to use one copy of an operating system for multiple computers brings another legal difficulty — software piracy.

Finally, you can replace the computer and operating system. A fast, reliable new computer can be purchased for less than $1,000. If your computer has a 486 or older CPU, this is the most cost-effective solution.

Office Practice Software

There are many billing and scheduling, practice management, and electronic medical records companies. Contact the company and inquire about Y2K-compliant software upgrades. If you have remained current in the company's upgrade path, then the Y2K version may cost little or nothing. Several electronic medical record companies initially charged physicians exorbitant upgrade fees. After public outcry, the companies agreed to upgrade for a minimal fee.

UNIX

Versions of the UNIX operating system are much less dependent on hardware BIOS settings than PC operating systems. Several versions of UNIX corrected Y2K date incompatibilities years ago. There may, however, be a date problem after the year 2048. If your computer system runs a UNIX operating system, you should contact the operating system provider or a computer consultant to determine Y2K compliance.

Conclusion

Personal computer preparedness is the safest way to avoid problems with the Y2K bug. This article addresses the most common areas of Y2K testing in office practice settings. MoMed

About the Author

Eugene R. Worth, MD, is President of Medical Information Technologies, Inc., a medical informatics and medical computing consulting company. Dr. Worth is also the Chair of the MSMA Physicians' Internet Advisory Committee.

Disclaimer

This article is an overview of the 'Year 2000' computer bug as it may affect Missouri physicians. Any products or solutions listed in this article are to be used in good faith and have no expressed or implied warrantee. Before testing a computer for Y2K compliance, a complete backup of your hard disk is recommended. Neither MSMA nor Dr. Worth endorses any product listed in this article.

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Vital information
available at your
fingertips.

Telemedicine Beyond the Technology

Karen E. Zanol, MD; Philip Anderson, MD

Telemedicine is the most promising method today for improving medical services for patients in remote, rural areas. Access to specialty physicians is limited in many counties of our state. Patients who require specialty care often travel long distances and incur substantial cost in travel and work lost. For others, this care is denied altogether because travel is impossible.

The concept of two doctors working collaboratively across a telecommunications line to solve one patient's problem is an idea whose time has come. By tradition, physicians work alone and in their own manner. Any intrusion into this autonomy has been resented, but this attitude is beginning to change and telemedicine is an important technology driving that change.

In Missouri we have a telemedicine network into isolated areas that has been well regarded nationally and held up as a model effort. Dermatology is naturally well suited for telemedicine because of the visual nature of its practice. At the University of Missouri, dermatology is our busiest telemedicine clinic. The quality of telemedical dermatology will be substantiated as the system is refined and results can be studied over years, but we see every reason for optimism, especially if we continuously improve our techniques as we gain experience. A principle ingredient in success will be the creation of true collaboration between the physicians on either end of the telephone line. A book has been prepared to aid in this effort.[1]

Telemedicine is not a new endeavor. Almost 40 years ago in Boston, one of us (PCA) had the memorable experience of doing clinical dermatology on black and white television where a television link was connecting the immigration service medical office at Logan Airport to Harvard Medical School.[2] After 1970, at the National Library of Medicine, studies were done to improve the quality of close-up video imaging of skin disease, and to understand the minimum standards for accurate visual diagnosis.[3] Studies were also done to verify the reliability of diagnosis by television.[4] Since then, the quality of the equipment has been dramatically improved, so that today an image satisfactory for clinical diagnosis can be shown in realistic full color with easy-to-use, light weight equipment. Today we have no excuses about seeing a poor picture. Our problems are in our own technique, not in technology.

Important issues now concern the development of a medical team able to use telemedicine hardware efficiently to help isolated patients in a cost-effective manner. To achieve this result, we recognize five essential steps.

1) The selection of proper sites for the link-ups.
2) The training of telemedicine assistants at these distant sites.
3) The development of trained teledermatologists who can practice efficiently on television.
4) The development of a working collaboration with the local physicians to effectively employ (and even enjoy) the benefits of the consultant's service.
5) The creation of a quality control system to assure patients are properly cared for after the electronic encounter.

These five issues concern management, development of skills, and quality control. Now that the technology is excellent the key to success is people, not just equipment. The development of the human resources needed for excellence in telemedicine is clearly as important as having the tools necessary to produce a quality picture.

As to the familiar complaint that telemedicine is only a toy, and that medical practice is better without it, we can issue a decisive denial. When telemedicine is directed to the care of underserved people, the benefits are unique and valuable.

Proper Sites

Our successes have been at sites having essentially no specialized dermatologic care, where telemedicine is a wonderful alternative to no consultative care at all. A long time association is an asset, as we have with rural VA hospitals through the Harry S. Truman Memorial Veterans Hospital in Columbia.

One of our most active teledermatology sites is with the John J. Pershing VA Medical Center in Poplar Bluff, Missouri. They have no dermatologist on staff and none in the community. We see 12 to 15 carefully chosen patients each week at Poplar Bluff, many of whom come from rural, isolated counties in southeastern Missouri and northeastern Arkansas. All patients seen in this clinic were surveyed in the months of July and August of 1998. Ninety-nine percent of surveys were returned and 100% of patients rated the service highly on all measures.

The Missouri Telemedicine Network based at University Hospital and Clinics in Columbia, Missouri, conducts dermatology clinics weekly and serves 14 rural counties from the mid-central section of the state. Many of these counties have no other dermatology services.

Although telemedicine can be practiced over very long distances, there is an advantage to being close enough for travel between sites for the rare occasion when it is imperative to see the patient in person. This assures quality for the patient and allows for clinical studies for auditing of quality.

Training the On-site Telemedicine Assistants

We have found it important to have the on-site assistants spend some time with us in our clinics learning common dermatologic terminology and basic procedural skills. These personnel are critical to the success of the practice. On-site assistants are usually clinic nurses who have a special interest in telemedicine. The skills needed are specific and extremely important to the long-term viability of the service.

Basic procedures can be demonstrated, then taught to the assistants who perform them under the direct visual supervision of the teledermatologist. The job description of the telemedicine assistant needs to be adapted to current practice. They must be able to do some simple procedures. For dermatology, this list should include the ability:

1) to describe tactile findings on skin examination under the direct visual supervision of the teledermatologist,
2) to clean up erosions and ulcers and remove stuck-on exudates,
3) to pare off the outer corneum of calluses and warts,
4) to apply an astringent, such as aluminum chloride, to an erosion.

A more advanced list would include:

1) applying liquid nitrogen to minor actinic keratoses or comparable lesions,
2) performing Unna's boot application,
3) doing a KOH examination for fungus and yeast or performing a mineral oil preparation for scabies that the dermatologist can then review under the telemicroscope,
4) doing a culture for herpes simplex or zoster after opening a vesicle,
5) taking a bacterial culture,
6) making a video to be seen later by the teledermatologist.

A key function of the on-site assistant is to conserve time-on-line. A telemedicine clinic may be unable to see patients if there are delays and it is limited to a set time when the line is open and/or available. It must run efficiently if all the patients are to be seen. The assistant should be prepared to use the camera skillfully and to organize the notekeeping, so that many tasks can be done off camera or later.

Training the Teledermatologists

Early, there was an erroneous but pervasive notion that a physician skillful in the development of therapeutic doctor-patient relationships in person would naturally be able to transfer these skills to telemedicine. We know now that there are particular behaviors that can be taught to assure physicians are effective in the practice of telemedicine.

Seasoned dermatologists often are not aware of how they make their diagnoses and decisions. When they are limited to vision alone in telemedicine, they are suddenly aware of their reliance on palpation,

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textures and subtleties of color or shading. The remedy is to practice using vision alone in the regular clinic, to evaluate those situations in which palpation and texture are essential, and to compensate for this lack. Physicians may wish to study the close-up view of lesions, because teledermatology offers mainly two distinct views, a " medium shot" and a "close up." Looking from all distances and angles is a luxury a doctor doing telemedicine will have to do without. They may need to rely more on the patient's history or details of symptoms. Our experience is that this adjustment can be made easily if one simply is aware of it.

The patient should feel that this is a real visit with the physician. Careful attention to theatre is important. It helps to use a pleasing background and to begin with a wide-shot that shows the patient the entire setting and who is in the room. This is followed by a close up on the consultant that gives the patient the best sense of a face-to-face encounter.

The patient's view of the doctor should show a warm-colored background with pictures on the wall and all the accessories of a nice office. It is a mistake to do telemedicine in a stark, ugly setting (the storage room look) because it gives the impression that the physicians consider telemedicine to be of little value, of poor quality, and only for patients who are destitute. In summary, telemedicine should be done from a "dressed-up" set. The same rules apply to the other end of the cable; the patient should be in the regular clinic not a spartan closet.

Lighting is important. In the clinic room, the lighting must be bright and rich in blue tones. Fluorescent bulbs are suitable; rooms with windows are to be avoided. The lighting should flood the field evenly and be movable. On the consultants side the lighting should be warmer (more red) and more subdued, to give a restful look.

The patient's sense of privacy can be enhanced by verbal reassurance and by minimizing background distractions. Speech is conducted in a normal tone, at a normal pace. The audio equipment available today is excellent and a normal tone of voice is sufficient. There may be a short delay in voice transmission; our current equipment gives us a quarter-second delay.

Small talk takes on an increased importance over the camera and helps to bridge the distance between physician and patient. Patients should be asked about themselves, other family members present – anything to help the physician reach through the television screen to "touch" the patient on the other side.

The examination is conducted in person if at all possible. While it is possible in many instances to make an accurate diagnosis from a high quality image acquired earlier, it is better to see the patient in person. The value of personal interactive consultation is to motivate the patient, inspire confidence and review instructions for medication use or skin care after the visit. The sense of a real visit to the doctor is an important educational device, and can be critical to medical outcome.

Collaboration Between Physicians

Telemedicine is best used as a tool for enhancing total quality of care where the specialty component of care is otherwise unavailable. It is not an effective means, as some fear, for competing for patients. Patients are always best cared for in person if possible.

When starting a new telemedicine practice, it is helpful for the consultant to personally visit the sites to be served in order to meet the local physicians and on-site telemedicine assistants. There is great potential for collaboration and for developing new professional relationships between physicians and other health care providers for the purpose of providing quality patient care. Building "doctor-doctor" collaborations is a major opportunity for telemedicine.

Quality Control Programs

Systems need to be in place to ensure that appropriate follow-up occurs after a telemedicine consultation. As with all consulting services, it must be made clear who is accountable for the patient's care, comfort and the outcome. It is naturally easiest if the local physician elects to manage the patient after the initial consult.

If, on the other hand, the diagnosis is best managed by the consultant, then systems need to be in place at the distant site to ensure that patients get the appropriate follow-up, in terms of lab work and return visits. Collaboration with the local physician is needed especially when managing patients with serious conditions such as immunobullous diseases, at a distance. Finally, the outcomes must be known and evaluated to establish that the telemedicine system is effective. Confidence in the system must be based on real outcome data.

Telemedicine is a tool best used with careful attention to both technology and human resources. Opportunities for improving quality of patient care in the rural areas of our state and for building new professional relationships abound. It is incumbent upon us to study our telemedical practice in order to refine our techniques, ferret out the weaknesses, and take full advantage of the many benefits. Our own experience with telemedicine has thus far been encouraging and rewarding.

The Authors

Both authors are associated with the University of Missouri-Columbia School of Medicine. Karen Edison Zanol, MD is an Assistant Professor of Dermatology and Director of the Residency Program. She is also Section Chief for Dermatology at the Harry S. Truman Memorial Veterans Hospital. Philip C. Anderson, MD, is Professor Emeritus of Dermatology.

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Relationship Between Conditional Early Acceptance into Medical School and Medical School Leadership and Academic Performance:

The Conley Scholar Experience at the University of Missouri-Columbia

Erik Stratman, MD; Ted Groshong, MD; Michael Whitcomb, MD

Abstract

The Conley Scholars Program at the University of Missouri-Columbia was created in 1987 to guarantee top flight students entrance to medical school without the frantic competition well known in undergraduate pre-med programs. The program provides greater freedom as undergraduates than most combined baccalaureate-MD programs. It is not known how this freedom and avoidance of the "pre-med syndrome" affects medical school performance and relative leadership qualities compared to traditional medical students. The goals of this study are to:

a) compare relative composition and performance of Conley medical students to traditional medical students;

b) assess the role of Conleys in leadership positions within medical school organizations.

Methods: Using the medical school computer data files and AMCAS application files, composition, academic, and leadership data were collected regarding all medical school classes containing Conleys. Statistical analysis was performed on all data.

Results: The results suggest that:

a) Conley Scholars averaged significantly higher undergraduate GPAs than other medical students;

b) Conley Scholars averaged higher GPAs throughout medical school;

c) Conley Scholars are more likely to hold medical school leadership roles than traditional medical students.

Conclusions: The results confirm the value of the Conley Scholar Program. Benefits extend beyond academic achievement to encompass the development of leadership skills recognized by faculty and peers.

Introduction

Curricular characteristics of combined baccalaureate-MD programs in the United States are quite varied.[1] In 1997, there were more than 33 such programs accounting for more than 900 medical students.[2] Although no two programs are alike, they all prepare medical students for patient care, teaching, or research.[1] There are little data in the literature comparing medical school academic performance of these early accepted students to their traditional medical school classmates in those medical schools which offer both admission types.[3]

There is no literature comparing leadership qualities of these two medical student populations. As the twenty-first century approaches, the medical profession will need leaders to step forward and address the health care challenges facing the physician. In addition, physicians are often perceived as community leaders expected to participate in politics, business, and volunteer activities.[4] Certainly, medical school programs which attract leaders benefit the medical profession.

The University of Missouri-Columbia School of Medicine offers a conditional, early acceptance program which provides greater freedom in the baccalaureate phase than most combined degree programs. It is not known how this program with its freedom and avoidance of the "pre-med syndrome"[5] affects medical school performance and relative leadership qualities compared to traditional medical students.

The Conley Scholars Program at the University of Missouri-Columbia (MU) was created in 1987 to guarantee top-flight undergraduate students entrance to medical school without the frantic competition well known in pre-med programs. The program was started in an attempt to attract outstanding students into the field of medicine at a time when the number of medical school applicants was declining. One goal of the program is to encourage bright students to come to MU to partake of all the undergraduate offerings that appeal to them. Another program goal is to get outstanding undergraduate students connected to the school so they continue their medical education at MU after graduation.[6]

To apply for the Conley Scholars Program, one must be a Missouri high school senior who has scored a minimum of 30 on the ACT or 1300 on the SAT. Selection is based upon evaluation of full academic credentials and personal qualities as determined through personal interviews and letters of recommendation. Applicants who have strong interest in returning to practice medicine in rural and other underserved areas of the state are particularly encouraged to apply.[7]

To remain in the program, those selected Conley Scholars must achieve a grade of B or higher in the required courses, with a cumulative grade-point average of 3.3 or higher in the undergraduate major of their choice. Finally, Conleys must complete 20 credit hours of Honors College courses.[7] Conley Scholars who have met the program requirements are not required to take the Medical College Admission Test (MCAT) and are assured acceptance into the School of Medicine at MU.[7]

In the 1990s, the number of medical school applicants are at an all-time high.[2] Ten years after the program's inception, objective data are needed to assess the value of the Conley Scholar Program. There are concerns surrounding the minimum undergraduate GPA requirement for Conleys (3.3) which is significantly lower than the GPA of matriculating traditional medical students. If objective data suggests inadequate relative performance by the Conleys, the program criteria should be reassessed.

One goal of this paper is to compare relative composition and performance of Conley Scholar medical students to non-Conley medical students.

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Table 1. Relative Composition, Performance and Medical School Leadership

	All-student analysis			Leadership subanalysis			Female subanalysis			Minority subanalysis		
	CS	NC	p<.05	CS Leader	NC Leader	p<.05	Female CS	Female NC	p<.05	Minority CS	Minority NC	p<.05
Total (n)	96	515	-	26	135	-	45	193	-	21	83	-
%Female	47	39		69	39	*			-			-
%Minority	22	17		27	14	*			-			-
%Non-pre-med	26	31		31	33				-			-
UG GPA	3.71	3.50	*	3.74	3.53	*	3.71	3.53	*	3.69	3.25	*
M1 GPA	3.24	3.03	*	3.33	3.14	*	3.27	2.93	*	3.30	2.71	*
M2 GPA	3.22	3.10		3.25	3.25		3.22	3.10		3.10	2.74	*
M3 GPA	3.64	3.50	*	3.70	3.60		3.69	3.53	*	3.58	3.14	*
M4 GPA	3.83	3.67	*	3.88	3.73		3.84	3.68	*	3.91	3.46	*
USMLE Step 1	211	204	*	210	209				-			-
Step 1 pass rate	100	96		100	97				-			-
USMLE Step 2	208	201		214	207				-			-
Step 2 pass rate	100	94		100	99				-			-
%Leadership roles	55	37	*						-			-

Note: CS = Conley Scholar medical student; NC = Non-Conley medical student; %Non-pre-med = percentage of students with a non-traditional pre-med undergraduate major; UG = undergraduate; GPA = grade point average; USMLE = United States Medical Licensing Exam; %Leadership roles = percentage of students who held medical school leadership role; * = statistically significant; (-) = no statistical analysis run.

Continued from page 93

Secondly, because Conley Scholars experience less academic pressure as undergraduates, it is hypothesized that they can use that time to cultivate their leadership skills through various extracurricular activities. This hypothesis shall be tested by assessing the role played by Conley Scholars in leadership positions within medical school organizations.

Methods

Data were collected from all medical school classes containing Conley Scholars (CS) beginning with the first year (M1) medical students in 1991-1992 and ending with all four medical school classes (M1, M2, M3, M4) in 1997-1998. The data collected were taken from the students' AMCAS application files as well as from the Student Information System (SIS-the medical school computer database). Data taken from the AMCAS application files included: sex, race, undergraduate major, and undergraduate (UG) grade point average (GPA). Data taken from the SIS files included: M1 GPA, M2 GPA, M3 GPA, M4 GPA, and USMLE Step 1 and Step 2 scores. Each of the UG majors recorded were classified as either "Traditional pre-med UG major" or "Non-Traditional UG major" as determined by the combined efforts of the dean's office. Finally, past and present leadership data from medical school organizations.

Statistical analysis was completed using the SPSS/PC + Statistics data analysis package. Statistical significance was considered p value < 0.05. Statistical analysis was performed on all CS vs. all non-Conley medical students (NC). For composition analysis, the Pearson Chi square was performed. For performance analysis, the t-test using two-tailed significance and equal or unequal variances (as determined by Levine's test for equality of variances) was performed.

Results

Table 1 summarizes the study results. For the study period, 96 CS (16% of the total medical student body) matriculated to the University of Missouri School of Medicine compared to 515 NC. Those 96 CS represented only 45% of the CS selected for the program. The 55% of CS non-matriculators either withdrew from the program to pursue other career paths, matriculated to other medical schools, or failed to meet program requirements. The average number of CS per class was 16 (range = 6 to 27). The percentages of females and minorities were higher in the CS group than in the NC group (47% vs. 39% and 22% vs. 17% respectively). There was no significant difference in choice of undergraduate majors between CS and NC. Twenty-six percent of matriculating CS chose non-pre-med majors compared to 31% of NC.

Conley Scholars matriculating to medical school averaged significantly higher UG GPAs than their NC medical school classmates (3.71 vs. 3.50). Similar results were obtained when female and minorities were analyzed separately.

Conley Scholars averaged significantly higher GPAs during medical school (see Table 1). The trend shows that Conley medical students averaged higher GPAs in each medical school year. Statistical analysis shows that CS scored significantly higher than NC as M1s, M3s, and M4s. Again, similar results were obtained when female and minorities were analyzed separately.

On the USMLE Step 1, CS scored significantly higher than NC (211 vs. 204). There was no significant difference between CS and NC regarding board scores on the USMLE Step 2 (208 vs. 201). The pass rate for CS taking USMLE Step 1 and Step 2 is 100% for each compared to 96% and 94%, respectively for NC.

Finally, the percentage of CS holding medical school leadership roles was significantly greater than the percentage of NC holding leadership roles (55% vs. 37%). Female leadership analysis shows 69% of CS leaders were female, significantly greater than the percentage of female NC leaders (39%). Minority leadership analysis shows 27% of CS leaders were minority, significantly greater than the percentage of minority NC leaders (14%). Academic leadership analysis shows CS leaders average higher GPAs during medical school than NC leaders.

Discussion and Conclusion

In order to attain the best possible applicants to medical school, selection committees should encourage students to enrich their undergraduate experience and avoid the "pre-med syndrome."[5,8,9,10,11] In addition, they should promote early acceptance into medical school while still requiring those selected students to obtain an undergraduate degree before matriculation.[5,8,9,10,11] These ideals are all incorporated into the CSP. The results of this study confirm the value of such ideals and the value of the CSP.

There are many benefits for students involved in the Conley Scholars program. The guaranteed acceptance relieves the pressure that traditional pre-med students feel.[6] Conley Scholars don't have to worry about how they will perform on the MCAT, and they don't have to go through the application or interview process again.[6] Flexibility is another important benefit.[6] Because Conley Scholars have been granted guaranteed acceptance into medical school, they have the freedom to pursue extracurricular activities and to undertake whatever undergraduate program or course of study they want. Non-traditional undergraduate majors were just as common in the NC group as among CS. It would appear therefore, at least with respect to those who matriculated in the medical school, that CS were not inclined to pursue non-traditional majors. This suggests that students who are interested in careers in medicine are, by virtue of their natural inclination, likely to major in traditional pre-med studies. UG major was the variable measured in this study to assess Conley UG diversification. A more accurate measure of UG diversification would include assessing UG extracurricular activities and leadership roles, data unavailable for this study period.

Based on relative percentages, the CSP has encouraged and benefited promising female and minority students to enter what once was a predominantly white male profession in the United States. A majority of CS selected have been female (55%). Whether these higher percentages represent a purposeful selection bias or merely a result of a higher percentage of female and minority CS applicants is unknown since complete CS applicant information (including sex and race) is unavailable. These female and minority CS who complete the program and matriculate to MU medical school average significantly higher GPAs than other female and minority medical students, both as UGs and as medical students. Based on these findings, the CS selection committee should consider increasing its role in encouraging outstanding female and minority high school students of Missouri to pursue a career in medicine.

This study does have major implications for the UG requirements of the CSP. It has been a concern that because CS must achieve an UG GPA of only 3.3 to qualify for matriculation, their cumulative GPAs would gravitate toward that mark. That would be significantly below the average UG GPA of NC (3.50), thus offering CS an unfair advantage. However, despite the minimum UG GPA requirement the average UG GPA of CS matriculating to MU medical school was significantly higher than the NC. The reason CS average superior UG GPA is not explained by their majoring in less challenging non-pre-med subjects, as already mentioned. It would appear, therefore, that CS were not inclined to take a more relaxed approach to their academic performance, and that highly motivated and successful students will perform at their level of ability regardless of the incentives and disincentives they face in doing so. This finding should dispel the notion that CS do not perform as well as NC as undergraduates. It is unnecessary to raise the minimum UG GPA requirement for CS at this time. A limitation to the UG GPA analysis is the fact that not everyone went to the same college or university. It may be relatively more difficult for a student to obtain a grade at one institution than to obtain that same grade at another.

This is the first report in the literature to compare medical leadership data between traditional medical students and medical students granted conditional early acceptance. Although there is no data on the leadership positions held by CS during their undergraduate experience, it is conceivable that CS did feel that the program allowed them to explore a variety of extracurricular activities that they might have avoided given the pressures of competition for entry to medical school. These skills they developed as a result carried over to their medical school experience. Although no definitive conclusions can be reached about this issue, it is interesting enough to deserve further study. Leadership is a valuable

Continued on page 96

quality which is evident in a majority of those selected for the CSP. Medical student leaders of today will be those solving the problems facing medicine in the twenty-first century.

The results of this study show that the CSP is an excellent program. Benefits are seen throughout each aspect of the program including undergraduate performance, medical school performance, and medical school leadership. This study should serve as the foundation for future assessment of the CSP. It should be expanded to assess residency program success and specialty selection. Finally, this study should serve as the foundation for leadership assessment of all U.S. medical schools which offer early, conditional acceptance into medical school to high school seniors.[2] MoMed

Acknowledgments

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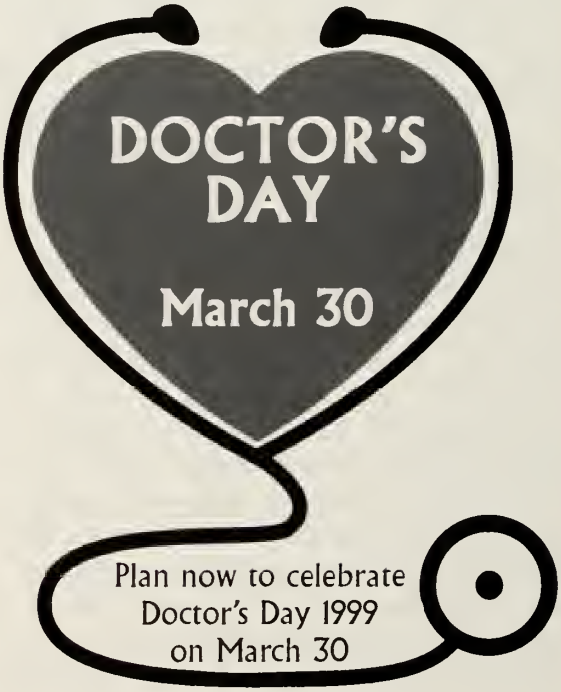

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141st Annual Convention
April 8-11, 1999

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MSMA Sponsored Annual Meetings and Events

Thursday, April 8

10:00-Noon	Opening Session, MSMA House of Delegates
1:30 pm	MSMA Reference Committees

Friday, April 9

9:00-10:30 am	MSMA General Session
11:00-12:30 pm	MSMA General Session
11:00-1:00 pm	Medical Student Delegate Luncheon
Noon-2:00 pm	General Session
1:00-2:00 pm	MSMA Organized Medical Staff Section
1:30-4:00 pm	MSMA General Session
4:00-6:00 pm	Second Session, MSMA House of Delegates

Saturday, April 10

8:00-Noon	MSMA Section on Young Physicians/International Medical Graduate Program
1:00-2:00 pm	Open Forum on AMA Issues
6:30-7:30 pm	MSMA Presidential Inauguration
7:30-9:00 pm	MSMA Reception

Sunday, April 11

7:30 am	Final Session, MSMA House of Delegates Breakfast Meeting

ANNUAL CONVENTION
General Sessions

Preserving the Physician-Patient Relationship in a Managed Care Environment

Friday, April 9 • 9:00 - 10:30 a.m.

Interactive Seminar Building Bridges: Enhancing the Physician-Patient Partnership

Friday, April 9 • 1:30 - 4:00 p.m.

Physicians are encouraged to make reservations for the Interactive Seminar.

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Eric W. Jacobson, MD, reviewer of the nationwide medical education offering, "Building the Physician-Patient Partnership."

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Friday, April 9
11:00 a.m. - Noon

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President, Medical Information Technologies
Columbia

Domestic Violence: Recognition, Documentation & Management

Friday, April 9 • Noon - 2:00 p.m.
Presented by: Zita Surprenant, MD, Lenexa, Kansas
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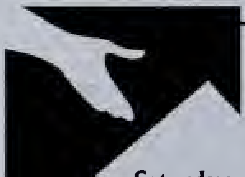

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Annual Meetings and Events

Thursday, April 8

7:00-4:00 pm	MSMA Registration
7:00-9:30 am	Moneta Breakfast
10:00-Noon	Opening Session MSMA House of Delegates
11:45-1:00 pm	St. Louis Metropolitan Medical Society Luncheon Caucus
Noon-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon Caucus
1:30 pm	MSMA Reference Committees Meeting
4:00-6:00 pm	MSMAA Registration
7:00 pm	MSMAA Dutch Treat Dinner

Friday, April 9

7:00-4:00 pm	MSMA Registration
7:00-8:30 am	Councilor Districts #1,2,5,6,8,9,10 Breakfast Meetings
7:30-8:30 am	MSMAA Continental Breakfast
7:30-9:00 am	University of Missouri-Columbia Alumni Organization Board of Governors Breakfast Meeting
7:30-2:00 pm	MSMAA Registration
8:30-11:30 am	MSMAA General Assembly
9:00-10:30 am	MSMA General Session
11:00-12:30 pm	Missouri Society of Otolaryngology - Head and Neck Surgery Scientific Presentation
11:00-12:30 pm	Missouri Dermatological Society, Inc. Scientific Presentation
11:00-12:30 pm	MSMA General Session
11:00-1:00 pm	Medical Student Delegate Luncheon
Noon-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon
Noon-2:00 pm	MSMA/Alliance General Session
12:30-2:00 pm	University of Missouri-Columbia Alumni Luncheon
1:00-2:00 pm	Missouri Society of Otolaryngology-Head and Neck Surgery Scientific Presentation
1:00-2:00 pm	MSMA Organized Medical Staff Section Business Session
1:00-4:00 pm	Missouri Chapter, American Academy of Pediatrics Scientific Presentation
1:30-3:00 pm	Missouri State Surgical Society Scientific Presentation
1:30-4:00 pm	MSMA General Session
2:00-4:00 pm	St. Louis Metropolitan Medical Society Caucus
2:45-4:00 pm	Missouri State Medical Foundation Business Meeting
4:00-6:00 pm	Second Session MSMA House of Delegates
5:00-6:30 pm	Missouri Chapter, American Academy of Pediatrics Reception
6:00 pm	Missouri Society of Eye Physicians and Surgeons Board of Directors Dinner Meeting
6:00-7:30 pm	University of Missouri-Kansas City, Washington University School of Medicine, University of Missouri-Columbia, St. Louis University School of Medicine Alumni Receptions
7:30-11:00 pm	AMA-ERF Fundraiser

Annual Meetings and Events

Saturday, April 10

7:00-2:00 pm	MSMA Registration
7:00-8:00 am	Missouri Association of Plastic and Reconstructive Surgeons Breakfast Meeting
7:00-9:00 am	Missouri Society of Otolaryngology-Head and Neck Surgery Breakfast Business Meeting
7:30 am	MSMAA Past Presidents Breakfast
7:30-8:15 am	Missouri Society of Eye Physicians and Surgeons Breakfast Meeting
8:00-10:00 am	MSMAA Registration
8:00-10:00 am	Missouri Radiologic Society Breakfast
8:00-11:00 am	Missouri Academy of Family Physicians Scientific Presentation
8:00-11:30 am	Missouri Association of Plastic and Reconstructive Surgeons Scientific Presentation
8:00-Noon	MSMA Section on Young Physicians/International Medical Graduate Program
8:30-Noon	Missouri Society of Eye Physicians and Surgeons Scientific Presentation
8:30-Noon	MSMAA General Assembly Second Session
9:00-10:30 am	Missouri State Neurological Association Scientific Presentation
9:00-11:30 am	Missouri State Surgical Society Scientific Presentation
9:00-11:30 am	MSMAA General Assembly
9:15-Noon	Missouri Society of Otolaryngology-Head and Neck Surgery Scientific Presentation
9:30-11:30 am	Christian Medical and Dental Society Scientific Presentation
10:15-12:30 pm	Missouri Academy of Family Physicians Scientific Presentation
11:00-Noon	MMPAC Meeting
11:30 am	Missouri Chapter, American Academy of Pediatrics Luncheon and Business Meeting
Noon	MSMAA Installation-Awards Luncheon
Noon	Missouri Society of Otolaryngology-Head and Neck Surgery Luncheon
Noon	Missouri Society of Eye Physicians and Surgeons Luncheon
Noon	Missouri Association of Plastic and Reconstructive Surgeons Luncheon
Noon	Missouri Radiologic Society Luncheon
Noon	Missouri State Surgical Society Luncheon
1:00 pm	Missouri Association of Plastic and Reconstructive Surgeons Scientific Presentation
1:00-2:00 pm	Open Forum on AMA Issues
1:00-4:00 pm	Missouri Radiological Society Scientific Presentation
1:00-4:00 pm	Missouri Society of Eye Physicians and Surgeons Scientific Presentation
1:00-4:00 pm	Missouri Chapter, American Academy of Pediatrics, MSMAA Scientific Presentation
1:00-5:00 pm	Missouri Chapter, American College of Emergency Physicians; Missouri Psychiatric Associatoin; and the Missouri Section, American College of Ob-Gyn Mini-Conference Presentation
3:00 pm	MSMAA Joint Convention Board Meeting
6:30-7:30 pm	MSMA Presidential Inauguration
7:30-9:00 pm	MSMA/MSMAA Presidential Reception

Sunday, April 11

7:30-9:00 am	Final Session MSMA House of Delegates
9:30-11:30 am	Christian Medical and Dental Society Scientific Presentation

CHRISTIAN MEDICAL & DENTAL SOCIETY

Sunday, April 11 9:30-11:30 am

Scientific Program

Scientific Program
(sponsored by the Christian Medical & Dental Society

Moderator: Richard Heimburger, MD

9:30 am
Clinical Spirituality
Robert Potter, MD
(followed by question/answer session)

10:10 am
Clinical Spirituality
Warren Lovinger, MD
(followed by question/answer session)

10:50 am
Clinical Spirituality
Richard Heimburger, MD
(followed by question/answer session)

Objectives: Following this educational offering, participants should have a better understanding of: 1) A judeo-Christian viewpoint on ethical, socio-economics, emotional and spiritual values in healing and caring in medical practice; 2) mechanisms to strengthen family, children and adolescent relationships; and 3) opportunities for short-term service and cross cultural teaching in the third world countries.

Needs: Member needs assessment prioritized the following areas essential to the emotion and spiritual values in the healing and caring a physician's practice of medicine: 1) Emotional and spiritual counseling in the office setting; 2) Strengthening the family through your practice; 3) Delivery of International Health Care: Preparation for Short-Term Service Overseas.

MISSOURI CHAPTER, AMERICAN COLLEGE OF EMERGENCY MEDICINE

MISSOURI PSYCHIATRIC ASSOCIATION

MISSOURI SECTION, AMERICAN COLLEGE OF OB-GYN

Saturday, April 10 1:00-5:00 pm

Scientific Program

Scientific Program
(sponsored by Missouri Chapter, American College of Emergency Medicine, Missouri Psychiatric Association, and the Missouri Section, American College of Ob-Gyn

Moderator: Howard Peth, Jr., MD

Medicine and the Law: Mini-Conference on the Federal EMTALA/COBRA Regulations

1:00 pm
The Basics of the EMTALA/COBRA Provisions
Howard A. Peth, Jr., MD

2:00 pm
Mechanics of the HCFA Investigation: What They Look for and How to Respond
Mitchelle Rezinicek, RN, JD

3:00 pm
The HCFA Medical Review: Where There's Smoke There's Fire
Ronald P. Rae, MD

4:00 pm
Informed Consent: Transfer Requests and Treatment Refusals Emergency Management of the Difficult Patient
Howard A. Peth, Jr., MD

Objectives: At the conclusion of this mini-conference, the participants will be able to: 1) State the legal requirements involved in patient transfers, 2) Define the terms patient transfer, medical screening examination, and stabilization, 3) Explain the emergency consent theory and how to evaluate a patient's capacity to give consent, 4) Understand the procedures employed by US federal and State of Missouri regulatory authorities in conducting investigations into alleged EMTALA violations, 5) Discuss the scope of sanctions available to HCFA in enforcing alleged EMTALA/COBRA violations, 6) Implement an effective EMTALA compliance program at your hospital, and 7) Understand how to respond to HCFA investigation into alleged EMTALA./COBRA violations.

Needs: Program content was selected from physician's comments obtained from previous program evaluations. Due to an increased number of EMTALA-related investigations, this educational activity is designed to ensure compliance with EMTALA/COBRA regulations to avoid catastrophic sanctions.

MISSOURI SOCIETY OF EYE PHYSICIANS AND SURGEONS

Saturday, April 10	7:30-Noon	Scientific Program
	1:00-4:00 pm	Scientific Program

Scientific Program
(sponsored by the Missouri Society of Eye Physicians and Surgeons

Moderator: Thomas Whittaker, MD

7:30 am
Refractive Surgery - What's New?
John Doane, MD
8:30 am
Ocular Inflammatory Disease
Ronald E. Smith, MD
10:00 am
Glaucoma, Retina and Anterior Segment Update
1:00 pm
Impact of Medical Record Documentation and Coding on Patient Care
Ms. Joy Newby
3:00 pm
Principles of Risk Management in the Ophthalmologist's Office
Paul Weber, JD

Objectives: Following the educational offering, participants will have a better understanding of: 1) Current opinions and research on ocular and systemic inflammatory disease with emphasis on diagnostic and treatment options; 2) Current controversies in ophthalmic subspecialties including glaucoma, retina, anterior segment and refractive surgery, and 3) Current practice modalities and their impact on patient care.

Needs: The procedures utilized to determine physician needs and interests were: 1) Annual survey of membership which includes questions concerning topics members would like to see in a scientific prgoram, 2) Board of Directors discussion of possible program topics based on their own experiences and discussions with colleagues back home, 3) Review of AAO annual meeting and other ophthalmology society programs, and 4) Review of current journals.

Other Activities
(sponsored by the Missouri Society of Eye Physicians and Surgeons)

Friday
6:00 pm
Board of Directors Dinner Meeting

Saturday
7:30 am
Breakfast with Meeting
12:00 noon
Luncheon

MISSOURI ACADEMY OF FAMILY PHYSICIANS

Saturday, April 10	10:15-12:30	Scientific Program

Scientific Program
(Missouri Academy of Family Physicians)

Moderator: Lawrence Rues, MD

10:15 am
Coding/Documentation Headaches and Remedies for 1999. Evaluation/Management Code Documentation Update.
Ms. Lisa Norr

Objectives: Following the scientific program, participants will have a better understanding of: 1) How to reduce your risk of audit; 2) 1999 changes to E/M Codes and Documentation; 3) Common problems and solutions of documentation; 4) Procedures to develop a medical record compliance program; and 5) AMA and HCFA update.

Needs: This requested educational offering is designed to provide physicians with an update on significant revision to Evaluation/Management Code Documentation Guidelines.

MISSOURI STATE NEUROLOGICAL ASSOCIATION

Saturday, April 10 9:00-10:30 am Scientific Program

Scientific Program
(Missouri State Neurological Association)

Moderator: Joseph Hanaway, MD

9:00 am
Advances in the Treatment of Epilepsy and Parkinson's Disease
Joseph Hanaway, MD

Objectives: After attending this educational offering, participants will have a better understanding of new and emerging treatment options for the neurology patient regarding Epilepsy and Parkinson's Disease.

Needs: Member comments and participant evaluations were utilized to select this educational activity.

MISSOURI SOCIETY OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY

Friday, April 9 11:00-12:30, 1:00-2:00 pm Scientific Program
Saturday, April 10 9:15-1:15 pm Scientific Program

Scientific Program
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Moderator: Greg Renner, MD

Friday
11:00-12:30 pm
The Diagnosis and Treatment of Obstructive Sleep Apnea
Jerry Templer, MD
Recognition and Treatment of Cancers and Other Cutaneous Lesions of the Scalp, Face, and Neck
Gregory Renner, MD

Saturday
9:15-Noon
Somnoplasty Using a Radiofrequency Needle
William Davis
New Concepts in Treatment of Differentiated Thyroid Cancer
Robert Zitsch, MD
Cosmetic Surgery of the Upper Face
Keith LaFerriere, MD

Objectives: Following the scientific program, participants will have a better understanding of: 1) Pediatric sleep apnea and localization of the obstruction and proper examination of aerodigestive tracts, 2) Early recognition, treatment and prevention of obstructive sleep apnea, 3) Conditions associated with both central and obstructive apnea, 4) Sciences involved in sleep and the relationship of Obstructive Sleep Apnea Syndrome, 5) Early recognition and treatment of basal, squamous and melanomatous lesions, and 6) Principles and methods of treatment of all aspects of skin cancer of the head and neck for family physicians and internists.

Needs: Participant evaluation and member requests have been instrumental in developing this educational activity on sleep apnea, head and neck lesions, diseases of the ear and surgical options for chronic sinusitis and cancer of the throat.

Noon-1:15 pm
A System for Intraoperative Monitoring of the Facial and Recurrernt Laryngeal Nerves
J. Lee Rea, MD
Update in Otolaryngic Allergy
Paul Cook, MD

Other Activities
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Saturday
7:00-9:00 am
Business and Breakfast Meeting
Noon
Luncheon with Program

MISSOURI CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Friday, April 9	1:00-4:00 pm	Scientific Program
Saturday, April 10	1:00-4:00 pm	Scientific Program

Scientific Program
(Missouri Chapter, American Academy of Pediatrics)

Moderator: Bernard Griesemer, MD

Friday
1:00-4:00 pm

STD's in Schools
Bernard A. Griesemer, MD
Media Literacy - What is the Media Teaching our Kids?
Bernard A. Griesemer, MD
School Health: It's Not Just Condoms and Cough Drops Anymore
Daryl Lynch, MD
Firearms Prevention
Denise Dowd, MD

Objectives: After attending this educational activity, participants will have a better understanding of health issues in today's school system and the importance of physician involvement.

Needs: Academy members' input was utilized to design this program to raise the level of awareness among physicians regarding school health issues today.

Saturday
1:00-4:00 pm
Same as Friday's program, co-sponsored by the Missouri State Medical Association Alliance.

Other Activities
(sponsored by the Missouri Chapter, American Academy of Pediatrics)

Friday
5:00-6:30 pm
Reception for AAP Members
Saturday
11:30 am
Luncheon and Business Meeting

Missouri Medicine

Journal of the Missouri State Medical Association

MSMA Art Exhibit . . .

MSMA members interested in art are urged to submit their work for the first MSMA Art Exhibit at the 1999 Annual Convention. The artwork will be displayed in the exhibit hall and judged by the members. The winner will be featured on the cover of our journal.

A limit of two entries will be accepted in the following categories.

- Paintings
- Drawings
- Photography
- Sculpture

To register or for more information please call Michelle Poire, Managing Editor at 573-636-5151.

MISSOURI ASSOCIATION OF PLASTIC AND RECONSTRUCTIVE SURGEONS

Saturday, April 10 8:00-11:30, 1:00 pm Scientific Program

Scientific Program
(Missouri Association of Plastic and Reconstructive Surgeons)

8:00-11:30 am
Where Are We Going and Why?
Mary McGrath, MD
1:00-4:00 pm
Plastic Surgery Update
Mary McGrath, MD
Results of and Indications for Preservation of Breast Implants
Leroy Young, MD

Objectives: After attending this program, participants will have a better understanding of: 1) Problems inherent in the current training programs; 2) Effective utilization of new and emerging technology; and 3) innovative surgical techniques.

Needs: Participant evaluations were instrumental in developing this educational offering for plastic and reconstructive surgeons.

1:00-4:00 pm *(continued)*
Implications for Replantation
Kerri Woodberry, MD
Tattoo Removal in Gang Members as Part of Their Rehabilitation
Edmond Cabbabe, MD

Other Activities
(sponsored by the Missouri Association of Plastic and Reconstructive Surgeons)

Saturday
7:00-8:00 am
Breakfast Business Meeting
11:30-1:00 pm
Luncheon

MISSOURI RADIOLOGIC SOCIETY

Saturday, April 10 1:00-4:00 pm Scientific Program

Scientific Program
(sponsored by the Missouri Radiologic Society)

1:00 pm
ACR Compliance Program Guidelines
Thomas R. Hoffman, MD
2:00 pm
Medicine and the Information Superhighway
John Oro, MD
3:00 pm
Missouri Healthcare Legislation
Harvey Tettlebaum, Esq.

Objectives: After this program, participants will have a better understanding of: 1) Principles of a compliance program and how this may be implemented, 2) How medicine is using the information superhighway, and 3) The impact of Missouri Legislation on patient care.

Needs: Participant evaluations along with suggestions from Society members were utilized to form this educational activity.

Other Activities
(sponsored by the Missouri Radiologic Society)

Saturday
8:00-10:00 am
Breakfast
Noon
Luncheon Meeting

MISSOURI STATE SURGICAL SOCIETY

MISSOURI CHAPTER, AMERICAN COLLEGE OF SURGEONS

AMERICAN CANCER SOCIETY, HEARTLAND DIVISION

Friday, April 9	1:30 pm	Scientific Program
Saturday, April 10	9:00-Noon	Scientific Program

Scientific Program
(sponsored by the Missouri State Surgical Society; Missouri Chapter, American College of Surgeons, and the American Cancer Society, Heartland Division

Moderators: Ann Peick, MD; Michael Bukstein, MD; and David Ora, MD

Friday
1:30 pm
TBA
Charles W. Van Way, MD

Saturday
9:00-11:30
Full Thickness Skin Graft Using Extremities of Ellipse as Donor
Max A. Heeb, MD
Noon
Prevention Trials for Breast Cancer
Steven B. Standiford, MD

Objectives: After attending this educational offering, participants will have a better understanding of: 1) Socioeconomic trends impacting surgery; 2) Surgical considerations for skin grafts; and 3) Current treatment options for breast cancer.

Needs: Program content was determined by physicians' comments on the 1998 Annual Convention participant evaluations.

Mystery Dinner Theater

Friday, April 9
7:30 pm
$60/person

Missouri State Medical Association Alliance

Mystery Dinner Theater
Dinner and Silent Auction

Proceeds to benefit
AMA-Foundation

SOAR
BEYOND THE CLOUDS
Missouri State Medical Association Alliance

Missouri State Medical Association Alliance
Marriott Tan-Tar-A Resort • Osage Beach, Missouri
April 8-10, 1999
REGISTRATION FORM FOR CONVENTION

Name (for badge) ______________________ Phone (_____) ______________
Address ____
City/State/Zip ____
County Alliance ____

Please check ALL that apply

National Officer _____
National Committee _____
State Officer _____
State Committee Chair _____
County President _____
County President-Elect _____
Past State President _____
Delegate _____
Alternate Delegate _____
Member-at-Large _____
Guest _____

Event	Cost per person	Number Attending	Total Cost
AMA Foundation Benefit (formerlyAMA-ERF) Friday, April 9, 1999	$60.00		

Make check payable to: **AMA-Foundation** (please designate the school and fund donation is to benefit)
Name of Medical School ____
Location (City and State) ____
Medical Excellence Fund ______________ Medical Student Assistance Fund ______________

Event	Cost per person	Number Attending	Total Cost
Dutch Treat Dinner Thursday, April 8, 1999 7:00 p.m.	$30.00	_____ Chicken _____ Prime Rib _____ Fish	
Lunch/Seminar with your Spouse ***"Domestic Violence: Recognition, Documentation & Management"*** Friday, April 9, 1999 12:00 noon	Complimentary *Payne Stewart Autographed Door Prize*		
Installation and Awards Luncheon Saturday, April 10, 1999 12:00 noon	$25.00		
TOTAL AMOUNT DUE (Make check payable to MSMAA Convention Fund)			

Please mail **BOTH** checks and registration form **ON OR BEFORE March 25, 1999** to:
Cindy Gregston, 2030 E. Nottingham, Springfield, MO 65804, Phone (417) 887-4034.

1999 MSMA Preregistration

____
Name

____
Mailing Address

____
Component Medical Society

PLEASE RETURN TO
MSMA, PO BOX 1028, JEFFERSON CITY, MO 65102
FAX 573-636-8552

☐ Delegate ☐ Member

Please complete and mail the above preregistration form to assure a quick on-site registration. Upon receipt of your preregistration form, you will be mailed a confirmation card to present at the convention registration desk. Your registration packet and name badge will be awaiting your arrival.

Also, please complete and mail (directly to Tan-Tar-A) the hotel reservation form below at your earliest convenience. Reservation deadline is February 19, 1999.

Hotel Reservation

Missouri State Medical Association's Annual Conventin • April 8-11, 1999

Tan-Tar-A Resort Osage Beach, MO 573-348-3131

Name: ______________________________
Address: ______________________________
City: ____________________ State/Zip: ____________________
Telephone: ____________ Arrival Date: ________ Arrival Time: ________ Departure Date: ________
Number of Persons: ____________________ Number of Rooms: ____________________
Payment Method: Cash/Check: ____________ Credit Card #: ____________ Exp. Date: ____________

Should you require accommodations with no steps due to a physical condition (wheel chair use, crutches, etc.), please indicate this.

Reservations are accepted on a space-available basis, so it is important to get your reservation in as soon as possible. Reservations will be accepted and confirmed up to the opening day of the convention, providing accommodations still are available. Reservations run from 4 p.m. on day of arrival until noon on day of departure.

PLEASE LIST NAMES OF ALL PERSONS SHARING SAME ACCOMMODATIONS.

ACCOMMODATIONS

Single/Double Occupancy	$90 per room/per day + tax
One-Bedroom Suites	$165 per room/per day + tax
Two-Bedroom Suites	$215 per room/per day + tax

Please indicate preference for room with ____ 1 bed ____ 2 beds ____smoking ____ nonsmoking

Cancellation Policy - We require an advance of one night's lodging or credit card guarantee to confirm reservations. Deposits are refunded/credited only when cancellation notice reaches the Tan-Tar-A office 72 hours prior to the day of arrival. Your deposit will be forfeited if you arrive later or depart earlier than the indicated date.

PLEASE RETURN FORM AND DEPOSIT TO:
MARRIOTT'S TAN-TAR-A RESORT RESERVATIONS DEPARTMENT PO BOX 188TT OSAGE BEACH, MO 65065-0861
ALL MAJOR CREDIT CARDS WILL BE ACCEPTED BOTH FOR PAYMENT AND DEPOSIT.

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MSMA's Key Contact Program

Your action in MSMA's Key Contact Program is good, basic citizenship.

The members of the Missouri State Medical Association are all constituents represented by elected officials at the local, state, and federal levels of government. These legislators place great emphasis on what their most active constituents have to say, for it is these constituents who vote either to help re-elect them to another term of office or elect someone else to take their job.

When constituent involvement in the political process is applied on legislative issues, it is described as "grassroots" lobbying. Grassroots lobbying on legislative issues is critically important when MSMA wants to pass, amend, or defeat various proposals. To enhance its government relations effort through grassroots activity, MSMA has created the ***Key Contact Program***.

Activities in the ***Key Contact Program*** are based on two central premises. First, government actions have their greatest impact at the community level. As such, local constituent pressures can be exerted to help influence how a legislator votes.

Second, government actions and activities have become so important to the medical community that the responsibility for legislative effectiveness must in part reside with physicians - not just with your MSMA lobbyists. While MSMA staff plays a fundamental role in the process, MSMA needs a broader base of political support to be more credible and effective.

Your action in MSMA's Key Contact Program is good, basic citizenship.

Traditionally, MSMA members have been called on to write their lawmakers concerning government relations problems. However, our political needs now require participation that is more than just an occasional, informal effort. What is required is a systematic approach: MSMA's ***Key Contact Program***.

MSMA's ***Key Contact Program*** matches lawmakers with physicians from their districts who will keep in touch on legislative issues. That means each senator and representative will have at least one, and hopefully dozens of physicians in their district willing to take the time to call or write whenever medical issues arise. MSMA staff keeps its Key Contacts informed and engages the network when critical votes are expected or when certain lawmakers need to hear from a physician in their district.

The ***Key Contact Program*** is:

- strictly nonpartisan;
- information as well as action oriented;
- good, basic citizenship;
- taking an active role in the government process;
- getting to know your elected representatives;
- making your views known to your legislators.

MSMA's ***Key Contact Program*** promotes the interest of all physicians, their families, and patients with government officials. MoMed

If you are interested in becoming a Key Contact, please fill out the form on page 99 and return it to the MSMA.

Most of the people in this house have never practiced medicine.

Become a Key Contact for the 1999 Legislative Session!

Goals of MSMA's Key Contact Program

- To promote the interests of your profession, your practice, and your patients through contacts with lawmakers;
- To better understand issues affecting medicine and be able to explain organized medicine's position to elected officials on a constituent basis;
- To inform other physicians of the impact of government legislation and regulation on their business and personal lives;
- To help legislators and other government officials understand the impact proposed legislation and regulations have on the health care delivery system;
- To motivate physicians, their patients, and their families to become involved in the political process.

Your Involvement is Key to Our Success!

The Key Contact Program has been very successful. We hope you'll give it a try.
It takes no special training. We'll guide you along the way.
Just copy and fill out the form below and return it to:
MSMA, P.O. Box 1028, Jefferson City, MO 65102, Fax: 573-636-8552.

My state representative is: ____________________

My state senator is: ____________________

My name: ____________________

Address: ____________________

Phone: ________________ Fax: ________________

MSMA Financial Statements

REPORT OF
MISSOURI STATE MEDICAL ASSOCIATION
December 31, 1998
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Council of
Missouri State Medical Association:

We have audited the accompanying Statements of Financial Position of Missouri State Medical Association as of December 31, 1998 and 1997, and the related Statements of Activities and Changes in Net Assets and Statements of Cash Flows for the years then ended. These Financial Statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

These Financial Statements are not in accordance with Generally Accepted Accounting Principles, which require investments in the subsidiary and the affiliate to be consolidated with the controlling entity.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, except for the above comments, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association as of December 31, 1998 and 1997, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

Our audits were made for the purpose of forming an opinion on the basic Financial Statements taken as a whole. The Schedules of Selected Expenses for the years ended December 31, 1998 and 1997 are presented for purposes of additional analysis and are not a required part of the basic Financial Statements. Such information has been subjected to the auditing procedures applied in the audit of the basic Financial Statements and, in our opinion, is fairly stated in all material respects in relation to the basic Financial Statements taken as a whole.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 25, 1999

STATEMENTS OF FINANCIAL POSITION
December 31, 1998 and 1997

	1998	1997
ASSETS		
CURRENT ASSETS		
Cash and Cash Investments (Note 2)	$ 1,271,523	$ 801,319
Accounts Receivable	33,162	74,751
Other Current Assets	3,560	5,505
Total Current Assets	1,308,245	881,575
INVESTMENTS		
Marketable Securities (Note 3)	6,539,026	6,203,522
Common Stock of Missouri State Medical Services, Inc. (Note 11)	187,277	166,199
Total Investments	6,726,303	6,369,721
LAND, BUILDING AND EQUIPMENT (Note 6)	445,701	478,469
OTHER ASSETS		
Cash Surrender Value - Insurance	54,895	47,576
Note Receivable, Missouri State Medical Services, Inc. (Note 12)	244,876	223,996
Interest Receivable, Missouri State Medical Services, Inc.	19,590	20,880
Total Other Assets	319,361	292,452
TOTAL ASSETS	$8,799,610	$8,022,217
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable and Accrued Expenses	$ 8,573	$ 9,904
Due to the American Medical Association	32,221	68,952
Deferred Revenue	454,979	429,461
Deferred Dues	25,266	-0-
Total Current Liabilities	521,039	508,317
DEFERRED COMPENSATION (Note 6)	30,000	25,000
Total Liabilities	546,898	533,317
MEMBERS' EQUITY	8,248,571	7,488,900
TOTAL LIABILITIES AND MEMBERS' EQUITY	$8,799,610	$8,022,217

The Notes to Financial Statements are an integral part of these Statements.

STATEMENT OF ACTIVITIES
For the Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Dues	$1,084,270	$1,130,770
Subscriptions	14,326	19,173
Exhibit Rentals	30,750	21,000
Advertising	52,821	49,785
Commissions on Collections	13,520	13,650
Investment Income (Note 7)	1,441,603	555,974
Administrative Fees and Office Rent (Note 8)	95,756	79,655
Seminars and Workshops	12,123	5,305
Physicians Health Foundation (Note 9)	182,695	191,995
Royalties (Note 13)	60,706	57,949
Unrealized Appreciation (Depreciation) On Investments (Note 1)	(547,618)	1,403,865
Other Revenue	52,015	50,475
Total Revenues	2,492,966	3,579,596
EXPENSES		
Salaries and Fringe Benefits	$ 744,470	$ 700,519
Office Expense (Note 14)	153,219	149,430
Membership Development	26,095	-0-
Travel Expense	13,177	11,335
Commissions and Committee Expense	22,932	10,619
Depreciation	40,518	39,474
MSMA Auxiliary	8,239	10,195
Journal Expense	82,613	88,939
Meeting Expense	263,858	288,294
Public Affairs	69,494	80,473
Consultant and Professional Fees	59,598	47,207
Public Relations Program	41,705	53,822
Student Awards	1,200	1,200
Tort Reform	3,840	3,849
Miscellaneous	4,867	6,954
Seminars and Workshops	11,608	17,209
Physicians Health Foundation (Note 9)	206,727	212,715
MSMA Health Education Foundation	215	2,482
Missouri State Medical Foundation	-0-	(21)
Total Expenses	1,754,375	1,724,695
Increase in Unrestricted Net Assets Before Equity in Net Income of Subsidiaries	738,591	1,854,901
Equity in Subsidiary of MSMI, Inc. (Note 5)	-0-	138
Equity in Subsidiary of MSMS, Inc. (Note 11)	21,080	362,716
INCREASE IN UNRESTRICTED NET ASSETS	759,671	2,217,755
UNRESTRICTED NET ASSETS, BEGINNING	7,488,900	5,271,145
UNRESTRICTED NET ASSETS, ENDING	$ 8,248,571	$7,488,900

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Unrestricted Net Assets	$ 759,671	$2,217,755
Adjustments to Reconcile Change In Net Assets to Net Cash Provided By Operating Activities:		
Depreciation	40,518	39,474
(Appreciation) Depreciation of Investments	547,618	(1,403,865)
Loss on Disposal of Equipment	725	1,561
(Increase) or Decrease in Accounts Receivables	41,589	10,907
(Increase) or Decrease in other Current Assets	1,946	3,685
(Increase) or Decrease in Cash Surrender Value	(7,319)	(15,147)
(Increase) or Decrease in Note Receivable, MSMS, Inc.	(20,880)	(21,229)
(Increase) or Decrease in Interest Receivable, MSMS, Inc.	1,290	(1,650)
Increase or (Decrease) in Accounts Payable	(1,331)	3,157
Increase or (Decrease) in Due to the AMA	(36,731)	(77,706)
Increase or (Decrease) in Deferred Revenue	25,518	236,270
Increase or (Decrease) in Deferred Compensation	5,000	5,000
Increase or (Decrease) in Deferred Dues	25,266	-0-
Total Adjustments	623,209	1,219,543
Net Cash Provided by Operations	1,382,880	998,212
CASH FLOW FROM INVESTING ACTIVITIES		
(Increase) or Decrease in Marketable Securities	$(883,122)	$(2,371,088)
(Increase) Decrease in Common Stock of	-0-	1,798,043
(Increase) or Decrease in MSMI, Inc. Investment	-0-	18,085
(Increase) or Decrease in MSMS, Inc. Investment	(21,080)	(378,940)
Purchase of Equipment	(8,474)	(22,186)
Net Cash Used Investing	(912,675)	(956,086)
NET INCREASE OR (DECREASE) IN CASH	470,204	42,126
CASH, BEGINNING	801,319	759,193
CASH, ENDING	$1,271,523	$ 801,319

NOTES TO FINANCIAL STATEMENTS
December 31, 1998 and 1997

Note 1.Summary of Significant Accounting Policies

Organization:

The Missouri State Medical Association was incorporated as a not-for-profit corporation under the laws of the State of Missouri. The Internal Revenue Service has granted exemption under Code Section 501 (c)(6).

Basis of Accounting:

The Financial Statements of the Missouri State Medical Association are prepared on the Accrual Basis of Accounting.

Dues:

Dues are assessed to members on a calendar-year basis. On December 31st of each year, members delinquent in payment of dues forfeit their memberships. The Association may also collect from members dues and assessments of the American Medical Association and County Medical Societies which are then forwarded to the respective organizations. The Association receives a fee for providing this service. Amounts received from members prior to January 1st of each year, which represents the subsequent year's dues, are recorded as Deferred Revenue.

Valuation of Accounts Receivable:

Accounts receivable are stated at face amount with no allowance for doubtful accounts. An allowance for doubtful accounts is not considered necessary because probable uncollectible accounts are immaterial.

Property and Equipment:

Property and equipment are carried at cost. Depreciation is computed by the straight-line method based on estimated useful lives of the related assets.

Use of Estimates:

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Income Taxes:

The Association is exempt from Federal Income Taxes under the Internal Revenue Code Section 501 (c)(6). Unrelated business income, to include advertising income, is subject to income tax.

Investments:

In prior years, the Association recorded investments in marketable equity securities at the lower of aggregate cost or market at the Statement of Financial Position date. In 1997, the Association adopted SFAS No. 124, "*Accounting for Certain Investments Held by Not-for-Profit Organizations*". Under SFAS No. 124, investments in marketable securities are valued at their fair values in the statement of financial position. Unrealized gains and losses are included in the change in net assets.

Note 2. Cash and Cash Investments

The balance of cash and cash investments consisted of the following at December 31st:

	1998	1997
Petty Cash	$ 50	$ 50
Cash in Bank, Executive Vice President Account	1,519	5,354
Cash in Bank, Treasury Account	1,047	9
Money Market Funds	724,557	338,606
Certificates of Deposit	544,350	457,300
TOTAL CASH	$ 1,271,523	$ 801,319

Note 3. Investment in Marketable Securities

All investments in marketable equity securities are shown at fair value in the financial statements. The cost, fair values, and cumulative unrealized appreciation of Association investments at December 31, 1998 and 1997, are summarized below.

----------1998----------

	Cost	Fair Value	Cumulative Unrealized Appreciation
Marketable Securities	$4,039,742	$6,539,026	$2,499,284
Total Investments	$4,039,742	$6,539,026	$2,499,284

----------1997----------

	Cost	Fair Value	Cumulative Unrealized Appreciation
Marketable Securities	$3,156,620	$6,203,522	$ 3,046,902
Total Investments	$3,156,620	$6,203,522	$3,046,902

Unrealized appreciation attributable to the current year totaled $(547,618) for 1998 and $1,403,865 for 1997. A net realized gain of $1,163,120 and $401,904 on the sale of marketable equity securities was included in revenue for the years ending December 31, 1998 and 1997, respectively.

Note 4. Land, Building and Equipment

Consists of the following at December 31st (at Cost):

	1998	1997
Land	$ 83,000	$ 83,000
Building	583,609	583,609
Furniture and Equipment	257,511	252,582
Total	924,120	919,191
LESS: Accumulated Depreciation	478,419	440,722
TOTAL LAND, BUILDING AND EQUIPMENT	$445,701	$478,469

Note 5. Subsidiary Merger

Effective March 31, 1997, M.S.M.I. Incorporated (MSMI) and Missouri State Medical Services, Inc. (MSMS), both For-Profit corporations wholly owned by Missouri State Medical Association, merged through a transfer of assets. MSMS emerged as the surviving corporation. As a result, the 200 shares of common stock of MSMI held by Missouri State Medical Association was canceled. The merger was approved by the Office of Secretary of State, Missouri on March 20, 1997, with final assets and liability transfer completed on April 20, 1997. All assets and liabilities of the two companies continue as one entity (MSMS) as of March 31, 1997. The combined entity continues to operate for the joint purposes of the composite companies.

Note 6. Deferred Compensation Plan

The Association entered into a deferred compensation agreement with its Executive Vice President on May 1, 1990, which provides for payments upon retirement, death or disability. The agreement also stipulates that a pro-rata settlement of benefits will be made in the event of voluntary termination of employment with the Association once five years of service is completed after the agreement becomes effective. The agreement is funded through an insurance policy.

At December 31, 1998 and 1997, the Associations's liability under the terms of these agreements were $30,000 and $25,000, respectively with the underlying cash surrender value of life insurance being $54,895 and $47,576, respectively.

On December 17, 1989, the Association adopted a Deferred Compensation Plan for employees pursuant to Internal Revenue Service Code Section 457. Within Internal Revenue Service guidelines, participants may elect to defer a portion of their income until retirement. Funds invested for these purposes amounted to $255,221 and $222,821 as of December 31, 1998 and 1997, respectively

Note 7. Investment Income

The following is a summary of investment income for the years ended December 31st:

	1998	1997
Interest on Cash Investments	$ 27,677	$ 25,087
Dividends	229,215	108,103
Realized Gain or (Loss) on the Sale of Marketable Equity Securities	1,163,120	401,904
Interest on Note to Subsidiary	21,590	20,880
TOTAL INVESTMENT INCOME	$1,441,602	$ 555,974

Note 8. Related Party Transactions

The Association provides administrative services to MSMS, Inc., (a wholly-owned subsidiary) and Missouri State Medical Foundation (an affiliate). For providing these services, the Association receives an annual fee from each of these organizations. For the years ended December 31, 1998 and 1997, the annual administrative fee assessed to Missouri State Medical Foundation was $24,000 and $22,500 respectively, and the administrative fee assessed to MSMS, Inc., was $18,000 and $24,000 respectively.

The Missouri State Medical Association provides significant support to the Missouri State Medical Association Physicians Health Foundation (an affiliate). The Association had accounts payable for Foundation related expenses in the amount of $948 and $1,897 at December 31, 1998 and 1997, respectively.

Note 9. Physicians Rehabilitation Program

In 1986, the Association established a Physicians Rehabilitation Program, the purpose of which is to motivate impaired physicians to voluntarily enter into treatment and to provide such a treatment program.

Funding for the program is provided by fees assessed to participants as well as from donations received from supportive individuals and organizations.

During 1992, the Missouri State Medical Association Physicians Health Foundation was separately incorporated. For the years ended December 31, 1998 and 1997, the Association received as income $182,695 and $191,995 from the Physicians Health Foundation and in turn paid expenses of $206,727 and $212,715, respectively. The resulting differences of $24,032 and $21,420 are considered in-kind contributions to the Physicians Health Foundation for the years ended December 31, 1998 and 1997.

Note 10. Pension Plan

The Association maintains a non-contributory Defined Benefit Pension Plan covering substantially all of its employees. Established April 1, 1959, the Plan has a March 31st year end. Eligibility requirements include a minimum of 12 service months and a minimum age of 21. Normal retirement age is 65 with provision for pro-rata benefits prior to 65. Vesting is scheduled over six years of covered service. The Individual Aggregate Actuarial Cost Method is used as the basis for the funding standard account computation. At March 31, 1998, the most recently available actuarial information, fair value of plan assets was $602,404 and $461,026, in 1997. Total benefit obligation for 1998 was $816,828 and $676,461, in 1997 with a vested benefit obligation for 1998 of $812,592 and $668,931, in 1997.

Employer contributions for FYE March 31, 1998, was $83,036 and $85,667, in 1997. Additional plan income was $89,008 and $47,138, in 1997, with expenses for 1998 of $88 and $53 in 1997, and benefits paid in the amount of $575 in 1998 and $6,989, in 1997, and net income (loss) for the plan year 1998 was $171,381 and $125,763 in 1997. There was no unconditional liability for any unfunded accumulated benefit obligation plus any prepaid pension cost, nor unfunded accumulated benefit obligation reduced by any unfunded accrued pension cost. Assets are invested primarily in government securities and corporate stocks and bonds.

Net periodic pension costs for 1998 of $85,137, $86,443 in 1997, was composed of employer's normal cost for 1998 $78,597 and $76,852, in 1997, amortization charge of $234 for both 1998 and 1997, and interest of $6,306 in 1998 and $9,357 in 1997.

Note 11. Investment in Unconsolidated Subsidiary-MSMS, Inc.

The Association's investments in MSMS, Inc., a 100% owned unconsolidated subsidiary, is carried at cost of $30,000 plus equity in the undistributed net earnings since the date of acquisition. At December 31, 1998 and 1997, the investment in the subsidiary is carried at $187,278 and $166,198 respectively.

Condensed financial data relating to the subsidiary follows:

BALANCE SHEETS

	1998	1997
ASSETS		
CURRENT ASSETS		
Cash	$ 20,750	$ 3,124
Investments	453,748	453,012
Employee Advances	-0-	500
Total Current Assets	474,498	456,636
PROPERTY AND EQUIPMENT		
Office Furniture and Equipment	3,460	3,460
LESS: Accumulated Depreciation	(3,114)	(2,442)
Total Property and Equipment	346	1,038
OTHER ASSETS		
Investment in MSO	-0-	1,000
Total Other Assets	-0-	1,000
TOTAL ASSETS	$474,844	$458,674

LIABILITIES AND STOCKHOLDERS' EQUITY

	1998	1997
CURRENT LIABILITIES		
Notes Payable	$244,876	$223,996
Accounts Payable	4,000	45,000
Accrued Expenses	19,100	2,600
Interest Payable	19,590	20,880
Total Current Liabilities	287,566	292,476
STOCKHOLDERS' EQUITY		
Common Stock, $1 par value, 30,000 shares authorized; 30,000 shares issued and outstanding	30,000	30,000
Accumulated Unrealized Gains (Losses) On Investments	161,210	353,548
Retained Earnings	(3,932)	(217,350)
Total Stockholders' Equity	187,278	166,198
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$474,844	$458,674

STATEMENTS OF INCOME AND EXPENSES

	1998	1997
Income	285,965	$172,516
Expenses	(56,047)	(163,348)
NET INCOME (LOSS)	$229,918	$ 9,168

Note 12. Note Receivable, Missouri State Medical Services, Inc.

The note represents monies advanced by Missouri State Medical Association to Missouri State Medical Services, Inc. for initial expenses. The note is a demand note in the amount of $244,876 and $223,996 at December 31, 1998 and 1997, respectively, with interest at the rate of 9.25% in 1998 and 1997. The interest rate adjusts annually on January 1st to the prime rate plus 1%.

Note 13. Royalties

Royalty income is received from Missouri Medical Insurance Co. for use of the Missouri State Medical Association name and various logos in the marketing and advertisement of its professional liability insurance and risk management products. For the year ended December 31, 1998 and 1997, royalty income received from Missouri Medical Insurance Co. was $35,000 annually.

An additional royalty of $20 per Missouri Medical Insurance Co. insured physician in the State of Missouri as of December 31st of each preceding year, is to be paid on or before February 15th of the following year. At December 31, 1998 and 1997, royalty income receivable totaled $19,500 and $19,500 respectively.

Note 14. Operating Lease - Automobile

The following is a schedule, by years, of future minimum rental payments required under an operating lease for the rental of an automobile that has an initial or remaining noncancelable lease term in excess of one year as of December 31, 1998:

Years ending December 31st:	
1999	576
Total	$ 576

Total rental expense for the years ending December 31, 1998 and 1997, totaled $6,918 and $7,399 respectively.

ACCOMPANYING INFORMATION

SCHEDULES OF SELECTED EXPENSES
For the Years Ended December 31, 1998 and 1997

	1998	1997
SALARIES AND FRINGE BENEFITS		
Salaries	$ 499,489	$473,339
Payroll Taxes	40,072	36,662
Employee Life and Disability Insurance	12,604	15,888
Employee Hospitalization Insurance	63,388	54,590
Employee Pension Plan Contribution	86,336	95,487
Deferred Compensation Plan Expense	42,581	24,553
TOTAL SALARIES AND FRINGE BENEFITS	$744,470	$700,519

OFFICE EXPENSES		
Occupancy Expense	$ 15,728	$ 16,513
Office Supplies	25,188	19,015
Computer Expense	6,638	749
Postage	23,747	20,048
Telephone	12,141	16,165
Insurance	7,441	11,587
Internet Expense	1,383	8,515
Taxes, Real Estate	4,484	4,370
Taxes, Other	1,701	3,444
Custodian Fee	20,588	17,619
Equipment Rental and Repair	17,546	18,611
Dues and Directories	16,634	12,794
TOTAL OFFICE EXPENSES	$153,219	$149,430
COMMISSIONS AND COMMITTEES EXPENSES		
Commissions:		
Commission on Medical Economics	$ 105	$ 397
Commission on Continuing Medical Education	17,679	9,915
Commission on Interspeciality Medicine	152	282
Total Commissions Expenses	17,936	10,594
Committees:		
Committee on Legislative Affairs	$ 26	$ 25
Committee on Planning	4,970	-0-
Total Committee Expenses	4,996	25
TOTAL COMMISSIONS AND COMMITTEE EXPENSES	$ 22,932	$ 10,619
MEETING EXPENSES		
Meetings:		
Annual Session	$ 85,459	$ 89,326
Council	50,984	56,785
AMA Candidacy	4,573	7,966
AMA Delegates' Expenses	103,732	112,907
President and Officers Expense	5,808	17,310
Student Section	2,549	2,765
Resident Physician Section	4,384	-0-
Discretionary Council Fund	6,269	1,235
TOTAL MEETING EXPENSES	$263,858	$ 288,294

Notice to members of MSMA:

The Annual Meeting of the **Missouri State Medical Foundation** is scheduled for 2:45 p.m., Friday, April 9, 1999, at the Tan-Tar-A Resort at Lake of the Ozarks.

The Notes to Financial Statements are an integral part of these Statements.

MSMF Financial Statements

REPORT OF
MISSOURI STATE MEDICAL FOUNDATION
December 31, 1998
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Foundation:

We have audited the accompanying Statements of Financial Position of Missouri State Medical Foundation as of December 31, 1998 and 1997, and the related Statements of Activities and Changes in Net Assets and Statements of Cash Flows for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Foundation as of December 31, 1998 and 1997, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 27, 1999

STATEMENTS OF FINANCIAL POSITION
December 31, 1998 and 1997

	1998	1997
ASSETS		
CURRENT ASSETS		
Cash (Note 2)	$ 85,825	$ 92,211
Mutual Funds (Note 3)	766,143	387,711
Investments in Government Issues (Note 3)	433,792	150,090
Loans Receivable, Current (Note 4)	250,000	250,000
Accrued Interest	-0-	2,875
Total Current Assets	1,535,760	882,887
NONCURRENT INVESTMENTS (Note 3)		
Investment in Mortgage and Asset Backed Issues	411,434	949,436
Common Stock of Schering-Plough	15,661	15,661
Total Noncurrent Investments	427,095	965,097
LOANS RECEIVABLE, LONG TERM (Note 4)	1,802,918	1,645,070
EQUIPMENT (Note 6)		
Office Equipment, Net	4,987	6,671
Software, Net	2,489	4,628
Total Equipment	7,476	11,299
TOTAL ASSETS	$3,773,249	$3,504,353
NET ASSETS		
UNRESTRICTED NET ASSETS	$3,773,249	$3,504,353

STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
For the Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES		
Interest on Student Loans	$ 247,848	$ 144,094
Investment Income	59,982	108,124
Contributions	2,725	1,950
Contribution-Missouri State Medical	-0-	162,495
Unrealized Appreciation Investments	91,947	37,016
Total Revenues	402,502	453,679
EXPENSES		
Administrative	24,000	22,578
Professional Fees	6,827	3,665
Printing and Meeting	684	1,231
Provision for Loan Losses	8,308	7,245
Depreciation	1,684	1,757
Amortization	2,138	2,138
Publications	88,113	-0-
Dues and Subscriptions	656	1,017
Telephone	910	470
Miscellaneous	286	1,192
Total Expenses	133,606	41,293
INCREASE IN UNRESTRICTED NET ASSETS	268,896	412,386
UNRESTRICTED NET ASSETS, BEGINNING	3,504,353	3,091,967
UNRESTRICTED NET ASSETS, ENDING	$ 3,773,249	$ 3,504,353

The Notes to Financial Statements are an integral part of these Statements.

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Unrestricted Net Assets	$268,896	$412,386
Adjustment to reconcile Change in Net Assets to Net Cash Provided by Operating Activities:		
Depreciation and Amortization	3,822	3,895
(Appreciation) of Investments	(91,947)	(37,016)
Loss on Disposal of Computer Equipment	-0-	1,110
(Increase) Decrease in Accrued Interest	(2,875)	5,518
Total Adjustments to Reconcile Change in Net Assets to Net Cash	(91,000)	(26,493)
Net Cash Provided by Operating Activities	177,896	385,893
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Office Equipment	-0-	(4,373)
Purchase of Investments	(1,021,630)	(1,397,155)
Proceeds from Maturity or Sale of Investments	995,196	1,107,606
Net Cash Used by Investing Activities	(26,434)	(293,922)
CASH FLOWS FROM FINANCING ACTIVITIES		
Increase in Loans Receivable, net of Allowance For Doubtful Accounts	(157,848)	(137,645)
Net Cash Used in Financing Activities	(157,848)	(137,645)
Net Increase (Decrease) in Cash	(6,386)	(45,674)
CASH, BEGINNING	92,211	137,885
CASH, ENDING	$ 85,825	$ 92,211

NOTES TO FINANCIAL STATEMENTS
December 31, 1998 and 1997

Note 1. Summary of Significant Accounting Policies

Organization:
Missouri State Medical Foundation was organized in 1961 for the purpose of making low-interest loans to medical students.

Basis of Accounting:
The Financial Statements of Missouri State Medical Foundation are prepared on the Accrual Basis of Accounting.

Loans Receivable:
Loans receivable are stated at face amount less an allowance for doubtful accounts of five percent of the loan balances at December 31, 1998 and 1997.

Income Taxes:
The Foundation is qualified as an exempt organization under Section 501 (c)(3) of the Internal Revenue Code and is not subject to Federal or State Income Tax.

Use of Estimates:
The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Financial Statement Presentation:
In 1996, Missouri State Medical Foundation adopted Statement of Financial Accounting Standards (SFAS) No. 117 "*Financial Statements of Not-For-Profit Organizations*." Under SFAS No. 117, Missouri State Medical Foundation is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Foundation also adopted SFAS No. 116 "*Accounting for Contributions Received and Contributions Made*" in 1996. In accordance with SFAS No. 116, contributions received are recorded as unrestricted, temporarily restricted, or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year ended December 31, 1996. In addition, Missouri State Medical Foundation has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

Investments:
In prior years, the Foundation recorded all investments at cost plus accrued interest to approximate market value. In 1997, the Foundation adopted SFAS No. 124, *"Accounting for Certain Investments Held by Not-for-Profit Organizations"*. Under SFAS No. 124, investments in marketable securities with readily determinable fair values and all investments in debt securities are valued at their fair values in the statement of financial position.

Note 2. Cash

Cash consisted of the following at December 31st:

	1998	1997
Cash in Bank, Checking	$ 8,509	$ 2,336
Money Market	77,316	89,875
TOTAL CASH	$85,825	$ 92,211

The Notes to Financial Statements are an integral part of these Statements.

Note 3. Investments

At December 31, 1998 and 1997 the Foundation's investments consisted of Government Issues, Taxable Bonds, Mortgage and Asset Backed Issues, a Mutual Fund Portfolio, and common stock of Schering-Plough. Investments in Government Issues, Taxable Bonds, and Mortgage and Asset Backed Issues are typically purchased and held to maturity. Those investments having maturity dates of one year or less are classified as current assets, while those having maturities in excess of one year are classified as noncurrent investments.

The cost, fair values, and cumulative unrealized appreciation (depreciation) at December 31, 1998 and 1997, are summarized below. Cost of the Mutual Fund portfolio is stated as cost plus reinvested interest and dividends. Cost of Mortgage and Asset Backed Issues is stated as original cost less principal payments made to date. All investments are shown at fair value in the Statement of Financial Position.

	1998		
	Cost	Fair Value	Cumulative Unrealized Appreciation (Depreciation)
Current Investments			
Government Issues	431,994	433,792	1,798
Mutual Funds	708,575	766,143	57,568
Total Current Investments	1,140,569	1,199,935	59,366
Noncurrent Investments			
Mortgage Backed Issues	418,756	411,434	(7,322)
Common Stock of Schering-Plough	-0-	15,661	15,661
Total Noncurrent Investments	418,756	427,095	8,339
Total Investments	$1,559,325	$1,627,030	$67,705

	1997		
	Cost	Fair Value	Cumulative Unrealized Appreciation (Depreciation)
Current Investments			
Government Issues	151,296	150,090	(1,206)
Mutual Funds	394,941	387,711	31,770
Total Current Investments	506,237	537,801	31,564
Noncurrent Investments			
Mortgage Backed Issues	954,699	949,436	(5,223)
Common Stock of Schering-Plough	-0-	15,661	15,661
Total Noncurrent Investments	954,699	965,097	10,438
Total Investments	$1,460,896	$1,502,898	$ 42,002

Unrealized appreciation attributable to the current year totaled $91,947 for 1998 and $37,016 for 1997.

Note 4. Loans Receivable

The following is a summary of the transactions affecting the loans receivable account for the year:

	1998	1997
Loans Receivable, Beginning of Year	$1,994,811	$1,849,921
New Loans	297,250	338,730
Principal Payments	(132,101)	(193,840)
LOANS RECEIVABLE, END OF YEAR	$2,160,966	$1,994,811
Allowance for Doubtful Accts, Beginning of Year	$ 99,741	$ 92,496
Current Year Provision	8,307	7,245
ALLOWANCE FOR DOUBTFUL ACCOUNTS, END OF YEAR	$ 108,048	$ 99,741

Note 5. Equipment

Office equipment is recorded at cost and depreciated over its estimated useful life on a straight-line basis.

Intangible assets, such as software, are recorded at cost and amortized over a 60-month period on a straight-line basis.

	1998	1997
Equipment at Cost	$ 9,153	$ 9,153
LESS: Accumulated Depreciation	4,166	2,482
BOOK VALUE	$ 4,987	$ 6,671
Software at Cost	$ 10,692	$ 10,692
LESS: Accumulated Depreciation	8,203	6,064
BOOK VALUE	$ 2,489	$ 4,628

Note 6. Related Party Transactions

The Foundation is assessed by the Missouri State Medical Association an annual fee for administrative cost. For the years ended December 31, 1998 and 1997, the Foundation paid the Association $24,000 and $22,500 respectively, for administrative costs. The Foundation also reimburses the Missouri State Medical Association for expenses paid by the Association on behalf of the Foundation.

Note 7. Missouri State Medical Association Trust

On August 10, 1995, Missouri State Medical Association established an irrevocable trust to satisfy certain subordinated notes payables to it's member physicians. Per the Trust Instrument, any monies remaining, after a two year period, were to be donated to the Missouri State Medical Foundation. In August 1997, the Foundation was presented $162,495.

The Notes to Financial Statements are an integral part of these Statements.

MSMA Physicians Health Foundation Financial Statements

REPORT OF
MISSOURI STATE MEDICAL ASSOCIATION
PHYSICIANS HEALTH FOUNDATION

December 31, 1998
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Association
Physicians Health Foundation:

We have audited the accompanying Statements of Financial Position of Missouri State Medical Association Physicians Health Foundation as of December 31, 1998 and 1997, and the related Statements of Activities and Changes in Net Assets and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Association Physicians Health Foundation as of December 31, 1998 and 1997, and the results of their operations for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants
January 26, 1999

STATMENTS OF FINANCIAL POSITIONS
December 31, 1998 and 1997

	1998	1997
ASSETS		
CURRENT ASSETS		
Cash	$ 2,497	$ 3,892
Accounts Receivable	35,515	21,335
Total Current Assets	38,012	25,227
PROPERTY AND EQUIPMENT		
Office Furniture and Equipment	14,537	13,856
LESS: Accumulated Depreciation	12,095	10,059
Total Property and Equipment	2,442	3,797
TOTAL ASSETS	40,454	29,024
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable (Note 3)	$ 948	$ 1,897
Total Current Liabilities	948	1,897
TOTAL LIABILITIES	948	1,897
NET ASSETS		
Unrestricted	39,506	27,127
TOTAL NET ASSETS	39,506	27,127
TOTAL LIABILITIES AND NET ASSETS	$40,454	$29,024

STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
For the Years Ended December 31, 1998 and 1997

	1998	1997
REVENUES (Note 2)		
Contributions, Cash	$ 87,737	$ 106,336
Contributions, In-kind (MSMA)	24,032	21,420
Service Fees	108,122	96,780
Total Revenues	219,891	225,141
EXPENSES		
Professional Services	140,500	130,023
Office Supplies	8,573	7,378
Travel Expenses	20,627	20,011
Telephone	8,693	10,441
Office Rent	3,810	2,520
Contracts Expense	17,285	36,274
Dues and Subscriptions	300	730
Education and Training	1,083	2,306
De Novo Program Expense	4,245	2,764
Bank Service Charge	361	418
Depreciation	2,035	3,304
Total Expenses	207,512	216,169
INCREASE IN UNRESTRICTED NET ASSETS	12,379	8,972
UNRESTRICTED NET ASSETS, BEGINNING	27,127	18,155
UNRESTRICTED NET ASSETS, ENDING	$ 39,506	$ 27,127

MSMA Physicians Health Foundation Financial Statements

STATEMENTS OF CASH FLOWS
INDIRECT METHOD
For the Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in Unrestricted Net Assets	$ 12,379	$ 8,972
Adjustments to reconcile increase in unrestricted Net Assets		
Depreciation	2,035	3,304
Increase in Accounts Receivable	(14,180)	(10,125)
Increase (Decrease) in Accounts Payable	(950)	(481)
NET CASH PROVIDED BY OPERATING ACTIVITIES	(716)	1,670
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Equipment	(679)	(1,092)
NET CASH PROVIDED BY INVESTING ACTIVITIES	(679)	(1,092)
NET INCREASE (DECREASE) IN CASH	(1,395)	578
CASH, BEGINNING OF YEAR	3,892	3,314
CASH, END OF YEAR	$ 2,496	$ 3,892

NOTES TO FINANCIAL STATEMENTS
December 31, 1998 and 1997

Note 1. Summary of Significant Accounting Policies

Organization:

Missouri State Medical Association Physicians Health Foundation was incorporated as a not-for-profit corporation under the laws of the State of Missouri on March 26, 1990.

The purpose of the Foundation is to support and promote quality professional health care through the sponsoring, supporting, initiating, funding, and establishing of the rehabilitation of chemically-dependent or mentally-impaired physicians.

The Foundation is a supporting organization under Internal Revenue Code Section 509 (a)(3). As such, the Foundation has common officers with the Missouri State Medical Association, a Section 501 (c)(6) organization. In addition, the six officers and directors of the Foundation are also directors and members of the Executive Committee of the Missouri State Medical Association.

Basis of Accounting:

The Financial Statements of Missouri State Medical Association Physicians Health Foundation are prepared on the Accrual Basis of Accounting.

Financial Statement Presentation:

In 1996, Missouri State Medical Association Physicians Health Foundation adopted Statement of Financial Accounting Standards (SFAS) No. 117. "Financial Statements of Not-For-Profit Organizations." Under SFAS No. 117, Missouri State Medical Association Physicians Health Foundation is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets.

Missouri State Medical Association Physicians Health Foundation also adopted SFAS No. 116, "Accounting for Contributions Received and Contributions Made" in 1996. In accordance with SFAS No. 116 contributions received are recorded as unrestricted, temporarily restricted, or permanently restricted support depending on the existence and/or nature of any donor restrictions. The adoption of SFAS No. 116 had no effect on net assets or the change in net assets as of or for the year endedDecember 31, 1997. In addition, Missouri State Medical Association Physicians Health Foundation has not received any contributions with donor-imposed restrictions that would result in temporarily or permanently restricted net assets.

Accounts Receivable:

Program service revenues are recognized when billed to participants and charged to accounts receivable. Accounts receivable are stated at face with no allowance for doubtful accounts as all probable uncollectible accounts have been written off or considered immaterial.

Property and Equipment:

Property and equipment are carried at cost on a straight-line basis over the estimated useful lives of the related assets.

Income Taxes:

The Foundation is qualified as a tax-exempt organization under Internal Revenue Code Section 501 (c)(3) and is not generally subject to Federal or State Income Tax.

Note 2. Revenues

The Foundation receives contributions from hospitals, physician groups, insurance companies, and interested individuals. Additionally, the Missouri State Medical Association underwrites a significant portion of operating expenses. Fees are also charged, in a nominal amount, to service recipients.

Note 3. Related Party Transactions

The Missouri State Medical Association (MSMA) provides significant support to the Foundation. MSMA had accounts payable for Foundation related expenses in the amount of $948 and $1,897 at December 31, 1998 and 1997, respectively.

The Notes to Financial Statements are an integral part of these Statements.

REPORT OF
MSMS, INCORPORATED

December 31, 1998
Jefferson City, Missouri

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Missouri State Medical Services, Inc.:

We have audited the accompanying Balance Sheets of Missouri State Medical Services, Inc., as of December 31, 1998 and 1997, and the related Statements of Income, Retained Earnings and Cash Flows for the years then ended. These Financial Statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these Financial Statements based on our audits.

We conducted our audits in accordance with Generally Accepted Auditing Standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the Financial Statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the Financial Statements. An audit also includes assessing the accounting principles used, and significant estimates made by management, as well as evaluating the overall Financial Statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the Financial Statements referred to above present fairly, in all material respects, the financial position of Missouri State Medical Services, Inc., as of December 31, 1998 and 1997, and the results of their operations and its cash flows for the years then ended in conformity with Generally Accepted Accounting Principles.

DULLE & ASSOCIATES, P.C.
Certified Public Accountants

STATEMENTS 0F FINANCIAL POSITION
December 31, 1998 and 1997

	1998	1997
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 20,750	$ 3,124
Investments - Assets-for-sale (Note 4)	453,748	453,012
Employee Advances	-0-	500
Total Current Assets	474,498	456,636
PROPERTY AND EQUIPMENT (Note 1)		
Office Furniture and Equipment	3,460	3,460
LESS: Accumulated Depreciation	(3,114)	(2,442)
Total Property and Equipment	346	1,038
OTHER ASSETS		
Investment in MSO (Note 5)	-0-	1,000
Total Other Assets	-0-	1,000
TOTAL ASSETS	$474,844	$ 458,674
LIABILITIES AND STOCKHOLDER'S EQUITY		
CURRENT LIABILITIES		
Notes Payable (Note 3)	$244,876	$223,996
Accounts Payable	4,000	45,000
Accrued Expenses	19,100	2,600
Interest Payable	19,590	20,880
Total Current Liabilities	287,566	292,476
STOCKHOLDER'S EQUITY		
Common Stock, $1 par value; 30,000 shares authorized; 30,000 shares issued and outstanding	30,000	30,000
Accumulated Unrealized Gains (Losses) on Investments	161,210	353,548
Retained Earnings (Note 2)	(3,932)	(217,350)
Total Stockholder's Equity	187,278	166,198
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$474,844	$458,674

STATEMENTS OF ACTIVITIES
AND CHANGES IN NET ASSETS
For the Years Ended December 31, 1998 and 1997

	1998	1997
INCOME		
Consulting Fees (Note 1)	$ -0-	$ 22,933
Recruiting Revenue	-0-	1,168
Interest and Dividend Income	2,857	635
Miscellaneous Income	203	-0-
Gain on Sale of Investments (Note 4)	282,905	147,780
Total Income	285,965	172.516
EXPENSES		
Salaries	-0-	$ 73,578
Administrative Fees (Note 3)	24,000	24,000
Travel and Entertainment	938	7,456
Rent	-0-	9,000
Telephone	512	4,141
Printing and Supplies	-0-	937
Contract and Professional Fees	8,507	9,370
Miscellaneous Expense	1,808	374
Provision for Bad Debts	-0-	12,921
Depreciation	692	691
Interest Expense	19,590	20,880
Total Expenses	56,047	163,348
NET INCOME (LOSS) BEFORE TAXES	229,918	9, 168
Provision for Income Taxes	16,500	-0-
NET INCOME (LOSS)	$213,418	$ 9,168

The Notes to Financial Statements are an integral part of these Statements.

MSMS, Inc. Financial Statements

STATEMENTS OF RETAINED EARNINGS
For the Years Ended December 31, 1998 and 1997

	1998	1997
BALANCE, BEGINNING	$(217,350)	$(242,741)
Net Income	213,418	9,168
Transfer of Net Assets from MSMI, Incorporated (Note 2)	-0-	16,223
BALANCE, ENDING	$ (3,932)	$(217,350)

STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 1998 and 1997

	1998	1997
CASH FLOWS FROM OPERATING ACTIVITIES		
Operations:		
Net Income or (Loss)	$ 213,418	$ 9,168
Adjustments to Reconcile Net Income (Loss) to Net Cash Provided (Used) by Operating Activities: Depreciation	692	692
(Increase) Decrease in Accounts Receivable	500	28,840
Increase (Decrease)in Accounts Payable	(41,000)	18,257
Increase (Decrease)in Accrued Expenses	16,500	-0-
Increase (Decrease) in Interest Payable	(1,290)	1,650
Net Cash Provided (Used) by Operating Activities	188,820	58,607
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Purchases	(276,855)	(89,915)
Investment Sales or Maturities, Net	83,781	5,450
(Investment) Write-off in MSO (Note 5)	1,000	(1,000)
Net Cash Provided (Used) by Investing Activities	(192,074)	(85,465)
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds from Short-term Debt	20,880	21,230
Redemption of Common Stock for Treasury	-0-	(2,000)
Net Cash Provided (Used) by Financing Activities	20,880	19,230
Net Increase (Decrease) in Cash from activities	17,626	(7,628)
Cash from Transfer of MSMI, Incorporated Net Assets	-0-	3,223
Net Increase (Decrease) in Cash	17,626	(4,405)
CASH, BEGINNING OF YEAR	3,124	7,529
CASH, END OF YEAR	$20,750	$ 3,124

NOTES TO FINANCIAL STATEMENTS
December 31, 1998 and 1997

Note 1.Summary of Significant Accounting Policies

Organization:

Missouri State Medical Services, Inc. was incorporated on February 2, 1994, under the laws of the State of Missouri. From inception to present, Missouri State Medical Services, Inc., was, and continues to be, a wholly-owned subsidiary of the Missouri State Medical Association, a not-for-profit corporation under Internal Revenue Service Code Section 501 (c)(6).

The Company receives consulting fees for managerial and advisory services to physician practices and managed care organizations. These fees represent substantially all of the Company's income. Additionally, the Company receives fees for presentations of seminars.

Basis of Accounting:

The Financial Statements of the Missouri State Medical Services, Inc., are prepared on the Accrual Basis of Accounting.

Accounts Receivable:

Consulting fees are recorded as revenue and charged to accounts receivable after initial services have been provided and the clients have agreed to proceed with the engagement. Some services are provided initially that may not be charged to the client if no further engagement is agreed upon. Accounts receivable are stated at face amount net of any allowance for doubtful accounts. The allowance for doubtful accounts is management's estimate of uncollectible accounts as of the balance sheet date, and actual results may vary from these estimates. There was no allowance for doubtful accounts at December 31, 1998 and 1997.

Property and Equipment:

Property and equipment are carried at cost. Depreciation is recorded on a straight-line basis over the estimated useful lives of the related assets.

Income Taxes:

The Company had an operating loss carryforward at December 31, 1997, of $230,000, all of which was used to offset against taxable income for the period ended December 31, 1998.

Note 2. Corporate Merger

Effective March 31, 1997, Missouri State Medical Services, Inc. (MSMS) and M.S.M.I., Incorporated, both For-Profit corporations wholly owned by Missouri State Medical Association (MSMA), merged through a transfer of assets. MSMS emerged as the surviving corporation. As a result, the 200 shares of common stock of MSMI held by MSMA was canceled. The Merger was approved by the Office of Secretary of State, Missouri on March 20, 1997, with final assets and liability transfer completed on April 20, 1997. All assets and liabilities of the two companies continue as one entity (MSMS) as of March 31, 1997. The combined entity continues to operate for the joint purposes of the composite companies.

Note 3. Related Party Transactions

Missouri State Medical Association is the parent corporation of Missouri State Medical Services, Inc.. The Association is organized as a not-for-profit corporation under the laws of the State of Missouri, and owns all of the 30,000 shares of capital stock authorized, issued and outstanding of the Company. The Association charges the Company for administrative fees and other expenses incurred by the Association on behalf of the Company. The Company owed the Association $4,000 and $45,000 for administrative fees at December 31, 1998 and 1997, respectively.

The Company has a demand note payable to Missouri State Medical Association in the amount of $244,875 and $223,996 at December 31, 1998 and 1997, respectively, with interest at the rate of 8.25% and 9.25% in 1998 and 1997, respectively. The interest rate adjusts annually on January 1st to the Chase Manhattan prime rate plus 1%.

Note 4. Investments

Investments in equity securities are classified as available-for sale and are carried at market. The cost of these investments, using the average cost method, was $306,426 and $99,464 at December 31, 1998 and 1997, respectively. The accumulative unrealized holding gains and losses resulting from the difference between cost and market value is reflected as a separate item in the Stockholders' Equity section of the balance sheet and is not reflected in current income. Gains and losses from the sale of investments are reflected in current income.

Note 5. Investment in MSO

On March 20, 1997, Missouri State Medical Services, Inc. contributed $1,000 to become a fifty percent (50%) member in Practice+Plus, L.L.C., a Management Services Organization (MSO) formed as a Missouri Limited Liability Company. The purpose of the MSO is to provide business, non-clinical, organizational and physician medical practice services and products through a statewide network of qualified physicians, vendors, physician services companies and other entities. This investment was deemed worthless and was written off during 1998.

The Notes to Financial Statements are an integral part of these Statements.

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Members In The News

Jon Rupright, DO, Jefferson City. was recognized by the American Osteopathic College of Rehabilitation Medicine with the Fellow Award for Outstanding Service in Advancement of Rehabilitation Knowledge of Head Injury Nationally. Also, Dr. Rupright recently presented "Mild Traumatic Brain Injury" at the Capital Region Medical Center-Family Practice Seminar in Jefferson City.

Steve Gnatz, MD, MHA; **Jon Rupright, DO**; and **Bob Conway, MD**; were selected by their peers to be included in the fourth listing of *The Best Doctors in America.*

Steve Gnatz, MD, MHA, recently gave several presentations. These include: "Ergonomic Evaluations of Work Stations" at Capital Region's Healthy Review in Jefferson City; "Medical Staff Issues in a Changing Health Care Financing Environment" at the Cambridge Health Resources Health Care Conference in Washington, DC; "Preparing Yourself for Physiatric Practice: Strategies for Dealing with the Changing World of Health Care Finance Delivery" and "Practice Management Web Technologies in Medicine: Virtual Collocation and Collaboration" both at the American Academy of Physical Medicine and Rehabilitation Conference in Washington.

In Memoriam

Murray E. Finn, MD, 74, St. Louis, died January 5, 1999. Dr. Finn was a psychiatrist and a member of the Missouri State Medical Association.

Floyd C. Atwell, MD, 85, Shawnee Mission, KS, died January 18, 1999. Dr. Atwell practiced obstetrics and gynecology and was a member of the Missouri State Medical Association.

Nathan Kimelman, MD, 86, Atlanta, GA, died January 19, 1999. Dr. Kimelman practiced internal medicine and was a member of the Missouri State Medical Association.

Ellsworth Trowbridge, MD, 87, Dallas TX, died January 31, 1999. Dr. Trowbridge was a psychiatrist and member of the Missouri State Medical Associatioon.

Classified Advertising

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AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

Paul N. Arnold, *Springfield*
Alan E. Bauman, *Kansas City*
Carol T. Berner, *Springfield*
Steven E. Buie, *Kansas City*
Richard A. Covert, *St. Louis*
Gary A. Dyer, *St. Joseph*
Melvin R. Hayden, *Camdenton*
James K. Hunter, *Fairfax*
James A. Junker, *St. Louis*
Charles R. Kelly, *Kansas City*
Richard H. Loeb, *Springfield*
Michael B. Loggan, *Liberty*
Alexander G. Mallouk, *Kansas City*
Jack M. Mantell, *Springfield*
Carl M. Myers, *Platte City*
Alejandro C. Ojascastro, *St. Louis*
Meredith C. Jorstad Payne, *St. Louis*
Robert O. Schaaf, *St. Joseph*
Clyde N. Shealy, *Fair Grove*
Michael E. Shinn, *Kansas City*
Thomas P. Wescott, *Holden*

CME Listing

March

3 - *St. Louis:* **10th Annual Joseph E. Flynn Lecture Series.** Call St. John's Mercy Medical Center 314-569-6290.

5 - *Springfield:* **Pediatric Advanced Life Support provider renewal course.** 5.50 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

8 - *St. Louis:* **State-of-the -Art Clinical Applications of Cardiovascular Nuclear Medicine: Diagnosis, Prognosis, and Myocardial Viability.** Call Mallinckrodt 314-362-7130.

10 - *St. Louis:* **Asthma Physician Preceptorship Program.** 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

12 & 13 - *St. Louis:* **14th Annual Symposium Advances in Hemostasis and Thrombosis.** 10 credit hours. Call St. Louis University 800-553-2712.

11 thru 13 - *St. Louis:* **7th Annual Refresher Course & Update in General Surgery.** Call Washington University 314-362-6287.

19 thru 21 - *St. Louis:* **Neurosurgical Approaches to the Carotid Artery.** Call St. Louis University 314-577-8167.

20 & 21 - *St. Louis:* **Neurosurgical Approaches to the Carotid Artery.** 14 credit hours. Call Sandy Turck 314-535-4000.

24 thru 26 - *St. Louis:* **11th National Noninvasive Diagnosis of Vascular Disease.** Call St. John's Mercy Medical Center 314-569-6290.

27 - *St. Louis:* **Hepatobiliary Disease.** Call St. Louis University 800-553-2712.

April

8 & 9 - *St. Louis:* **31st Annual Matt Weis Symposium.** Call St. John's Mercy Medical Center 314-569-6290.

12 - *St. Louis:* **Leroy Sante Lecture.** Call Mallinckrodt 314-362-7130.

14 - *St. Louis:* **Asthma Physician Preceptorship Program.** 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

16 - *Kansas City*: **5th Annual Symposium for and about Women Physicians.** 6 credit hours. Call Kim McChesney 816-932-5140.

16 thru 18 - *St. Louis:* **ATLS** Call St. Louis University 800-553-2712.

16 thru 18 - *St. Louis:* **Mental Health & Aging.** St. Louis University 800-553-2712.

16 thru 18 - *St. Louis:* **Sexuality and Aging.** 13.75 credit hours. Call St. Louis University 800-553-2712 or 314-577-8167.

18 - *St. Louis:* **Sinusitis: Into the New Millennium.** 7 credit hours. Call St. Louis University 800-553-2712.

19 thru 23 - *St. Louis:* **Medicolegal Death Investigator.** Call St. Louis University 800-553-2712.

22 thru 24 - *St. Louis:* **Surgical Approaches to the Skull Base.** 22 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

23 & 24 - *St. Louis:* **Oncology in the New Millennium.** 11.5 credit hours. Call Washington University 314-362-6287.

29 & 30 - *St. Louis:* **Couples Therapy in the 90s: Advances and Innovations.** Call Judith Brandes 314-569-6290.

May

3 thru July - *St. Louis:* **Health Care Ethics in a Pluralistic Society: The Catholic Perspective.** Call St. Louis University 314-577-8167.

10 - *St. Louis:* **Musculoskeletal Radiology.** Call Mallinckrodt 314-362-7130.

25 & 26 - *Springfield:* **Pediatric Advanced Life Support.** 16 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

June

4 & 5 - *Branson:* **Update for Primary Care Physician.** Call St. Louis University 800-553-2712.

4 & 5 - *St. Louis:* **Neurosurgical Endoscopy.** 14 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

6 - *St. Louis:* **Endoscopic Release of the Carpal Tunnel.** 6 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

9 - *St. Louis:* **Asthma Physician Preceptorship Program.** 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

9 thru 11 - *St. Louis:* **Summer Geriatrics Institute.** Call St. Louis University 800-553-2712.

17 thru 20 - *Lake of the Ozarks:* **MAFP 51st Annual Meeting.** 18+ possible credit hours. Call 816-941-3939.

July

10 & 11 - *Springfield:* **Pediatric Advanced Life Support.** 16 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

14 - *St. Louis:* **Asthma Physician Preceptorship Program.** 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

Continued on page 116

Continued from page 115

25 thru 30 - ***Kansas City:*** **The Second Annual Greater Kansas City Internal Medicine Board Review Course.** 43 credit hours. Call Kim McChesney 816-932-5140.

26 thru 29 - ***St. Louis:*** **Masters: Advanced Death Investigation.** Call St. Louis University 800-553-2712.

August

11 - ***St. Louis:*** **Asthma Physician Preceptorship Program.** 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

20 thru 22 - ***St. Louis:*** **Cervical Spine Decompression and Stabilization.** 18 credit hours. Call Sandy Turk, Practical Anatomy Workshop of St. Louis University 314-535-4000.

September

10 - ***Springfield:*** **Pediatric Advanced Life Support provider renewal course.** 5.50 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

27 thru 29 - ***St. Louis:*** **Sellar & Parasellar Pituitary Tumors.** 15 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

October

1 thru 10 - ***St. Louis:*** **The Pterional Approaches.** 32 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

15 - ***Springfield:*** **Advanced Pediatric Advanced Life Support instructor course.** Call Maryann Jeter 417-885-5400 or 800-835-5201.

November

12 & 13 - ***St. Louis:*** **Neurosurgical Endoscopy.** 14 credit hours. Call Sandy Turk, Practical Anatomy Workshop St. Louis University 314-535-4000.

12 thru 14 - ***Branson:*** **MAFP Fall Conference.** 10+ credit hours. Call 816-941-3939.

14 - ***St. Louis:*** **Endoscopic Release of the Carpal Tunnel.** 6 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

19 - ***Springfield:*** **Pediatric Advanced Life Support instructor course.** Call Maryann Jeter 417-885-5400 or 800-835-5201.

20 & 21 - ***Springfield:*** **Pediatric Advanced Life Support.** 16 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

December

10 thru 12 - ***St. Louis:*** **Craniofacial Surgery and Transfacial Approaches to the Skull Base.** 24 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

New Members

MSMA

Sargent, Eric W. MD OTO
3635 Vista Ave. Box 15250
St. Louis, MO 63110
Univ of Michigan-Ann Arbor 1986

CAPE GIRARDEAU

Kluttz, Alywin E. MD FP
35 Doctors Park
Cape Girardeau, MO 63702
Univ of Chapel Hill-NC 1979

Scott, Benn L. MD EM
5891 County Rd., #621
Cape Girardeau, MO 63701
Loma Linda Univ-Loma Linda, CA 1976

ST. LOUIS METROPOLITAN MEDICAL

Jones, Miles J. MD PTH
1704 SE 11th St.
Lee's Summit, MO 64081
Howard Univ, Washington Univ 1977

ST. LOUIS METROPOLITAN MEDICAL RESIDENTS

Grenevicki, Lance F. MD GS
1121 W. 76th St.
Kansas City, MO 64114
Univ of MO-Kansas City 1999

NORTHEAST

Barker, Patricia L. MD GS
711 Grand Hannibal Clinic
Hannibal, MO 63401
Univ of MO-Columbia 1992

PETTIS

Johnson, Dennis L. MD PTH
PO Box 1706 Lab Bothwell Hospital
Sedalia, MO 65302
Univ of CO-Denver 1974

TRI-LAKES

Kapoor, Alka MD IM
PO Box 1100
Hollister, MO 65672
King George's Medical Col-Lucknow, India 1997

Mire, Louis E. MD EM
Skaggs Community Hospital ER
Branson, MO 65615
Louisiana St. Univ-New Orleans 1973

Missouri Physicians Health Program

MPH Program

Help for Physicians

The Missouri Physicians Health Program (MPH) is available to help Missouri physicians suffering from alcoholism, chemical dependency, and psychiatric illness. The aim of the program is to facilitate the professional functioning through early identification, intervention, and treatment.

This is a confidential service provided by the Missouri State Medical Association. The hotline is answered only by Jack L. Croughan, MD, Medical Director or Robert Bondurant, RN, LCSW, Program Coordinator. This is an opportunity to speak with a trained professional about any actual or possible impairment issue.

The MPH Program is available statewide. Representatives and services are located in principal urban centers to provide the most convenient access to services.

The Missouri Physicians Health Program has many years of experience in assisting physicians who are experiencing a variety of impairment issues. Access to the most appropriate sources for evaluation and treatment is available. A quality monitoring program is provided which has earned a strong reputation for credibility and therefore, a high degree of reliability in our effort to advocate for any Missouri physician.

A brochure and other educational information concerning the Missouri Physicians Health Program are available upon request. All inquiries are welcomed.

De Novo

for Spouses and Families of Missouri Physicians

De Novo means, "new beginning" and signifies hope and confidence in the future.

De Novo began as an adjunct to the Missouri Physicians Health Program when it was recognized that the spouses and families of these physicians could also benefit from similar services.

Confidentiality is a fundamental guarantee. The support groups are facilitated by an experienced professional and the participants are all from within the medical family community. This allows for a common understanding, as well as the promise of a safe environment where sensitive issues may be discussed with a strong sense of personal security.

Issues brought to the support group setting include substance abuse, mental illness, physical violence, relationship difficulties or any other subject that a family member perceives to be a problem.

The group facilitators are available to assist family members in identifying resources in addition to the group. They have the experience and knowledge to direct an individual to the appropriate community/professional resources.

The MSMA Alliance is a key supporter of the De Novo program. For more information, contact an Alliance member or call the number below.

Missouri Physicians Health Program
3839 Lindell Blvd., St. Louis, MO 63108
•Hotline: 1-800-274-0933 •Office: 314-995-4990 •Fax: 314-652-6033

If you have paid your MSMA dues, THANK YOU.

If not, this will be your last issue of *Missouri Medicine* .

Guide to Membership Benefits

MSMA offers value for your membership dues, the second lowest state medical association dues in the nation! Below are a some of the benefits MSMA members receive. For more information on membership, please contact MSMA at 573-636-5151.

- **Legislative Representation**
- **Watchdog Over State and National Bureaucracies**
- **Ombudsman for Managed Care Problems**
- **Free subscriptions to *Missouri Medicine, Progress Notes,* and the *Legislative Report***
- **Physician's Guide to Law and Medicine**
- **Continuing Medical Education**
- **MSMA's World Wide Web Site: http:www.msma.org**
- **MSMA Gold MasterCard** (HIV Coverage)
- **Missouri Physicians Health Program**
- **Collection Services**
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Missouri Medicine

Journal of the Missouri State Medical Association

April 1999

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CORRECTION

The following information was omitted from the February 1999 issue of *Missouri Medicine.* Kazim Sheikh, MD, and Claudia Bullock, the authors of the article, "Urban-rural Differences in Medicare in Missouri," (1999;96:67-73), are affiliated with the Health Care Financing Administration in Kansas City, Missouri. The views expressed in this article do not represent the views or policies of the Health Care Financing Administration or the United States.

On the Cover: "Tree Planting" - by Dale Nichols. This gouache on paper is 12½" x 8¼" and was painted circa 1940. It is from the collection of Harry B. Cohen, MD, Columbia Missouri, who practices anesthesiology in Mexico, Missouri.

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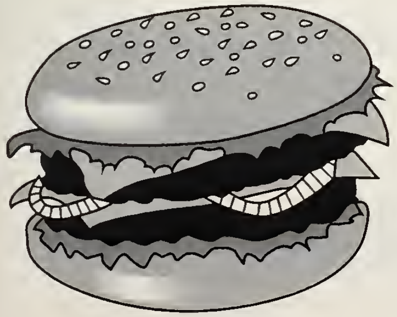
Editor's Desk

McHealthy

J. Regan Thomas, MD

Although I sense we are getting better, I think it is fair to say that diet and nutrition have not been stressed as much as they could be in most of our practices. Nearly all of our patients, of course, know that they should eat properly and have a grasp of what a "balanced diet" should include. The reality is that most American's eating patterns are changing and fast food, eating out, or meals "on the go" are becoming the norm.

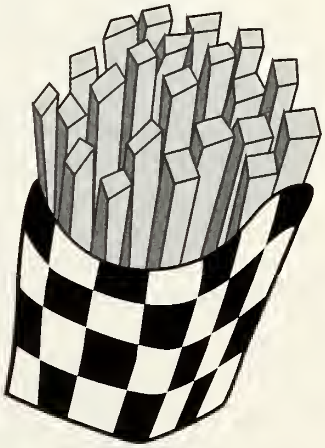
An Associated Press report recently noted that Americans are now eating out twice as frequently as they did in the 1970s. Our population eats about 30% away from home now as compared to only about 16% in 1977. The report was quoting the recent Agriculture Department survey which noted that when Americans eat out they often neglect fiber, iron and calcium, and increase their intake of saturated fat. Ironically, home cooked meals seem to be improving on those counts, but the trend is for people to eat out more often.



Agriculture Secretary, Dan Glickman, has termed this scenario the "nutritional gap." He has called for greater nutrition information through the schools or other educational forums.

It seems to me that the trend of eating out is only going to increase in the foreseeable future. Have you been to McDonalds lately, or you local mall food court? An entire generation or more now thinks of meals in these environments as normal and common place rather than as an occasional treat. Any metropolitan area now literally has fast food franchises on almost every block and street corner. With more families having both adults working and affordable franchised restaurants more and more available, this trend is unlikely to reverse itself.

> Our population eats about 30% away from home now as compared to only about 16% in 1977.



Perhaps a better approach is to encourage the fast food outlets to provide healthier food. Some chains have indeed offered lower fat choices but found less interest from consumers and so did not pursue it aggressively. The answer is to provide nutritious, healthy food that tastes good. It can be done (your mom did it at home!) and would be advantageous to marketing their products. It must also be packaged and marketed in the same way that their present products are. New, exciting, tasty, and innovative products which are also healthy can only help the restaurant business.

In the long run, their customers will be around longer to continue buying their products.

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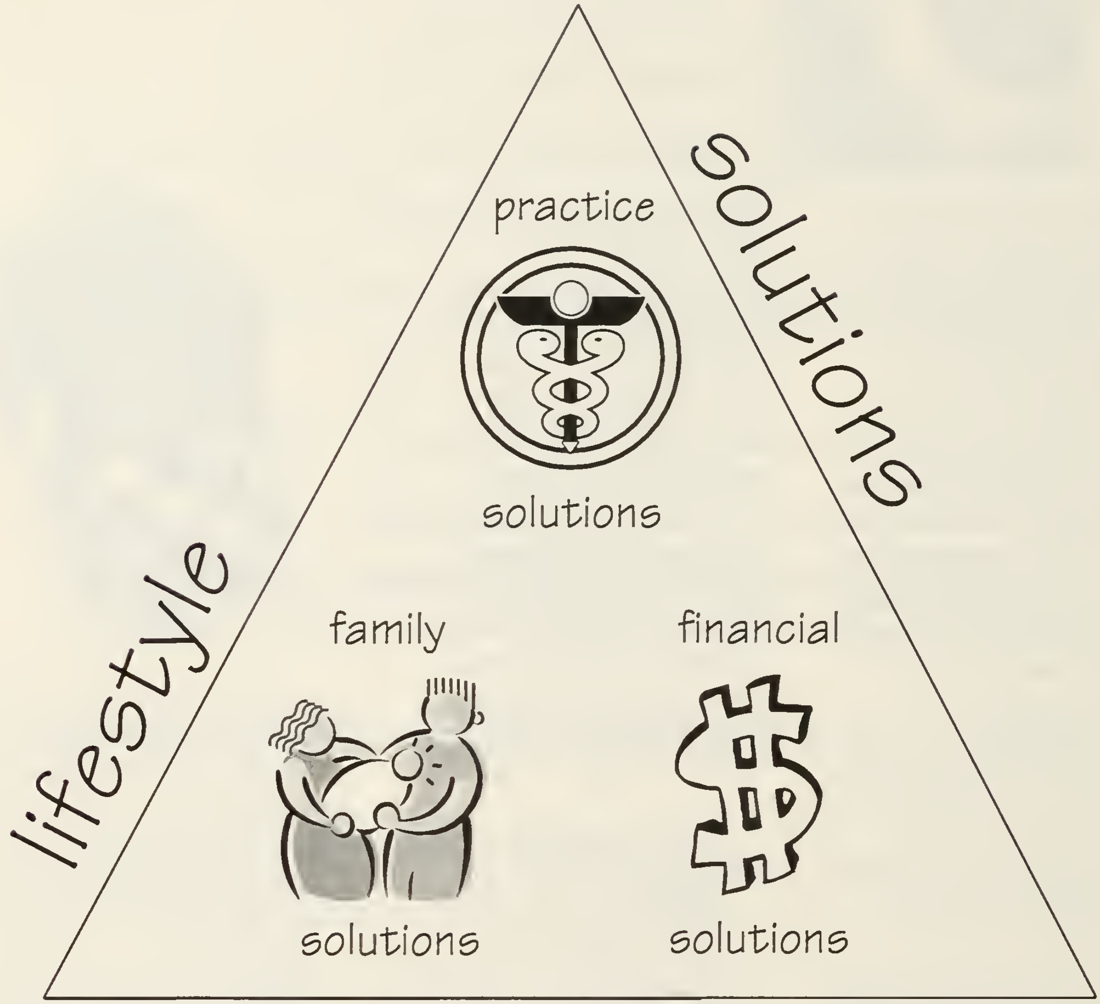
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To Whom It May Concern:

I just wanted to let you know how much I appreciate the continued outstanding results and hard work that the Missouri State Medical Association does on my behalf.

I also wanted to express my appreciation for both the excellent concise updates and the inclusion of an appropriate amount of humor on the Legislative Report.

I don't know who in your editorial staff bears this responsibility, but I feel they do an outstanding job and have certainly incited me on several occasions to specifically contact or write my Legislators to follow up on recommendations or suggestions made in your report.

Perhaps more than anything else, this type of follow up reinforces to us the valuable action of our State Association in defeating stupid knee jerk legislative band-aids to major hemorrhaging wounds.

Thank you again on behalf of physicians in the state of Missouri.

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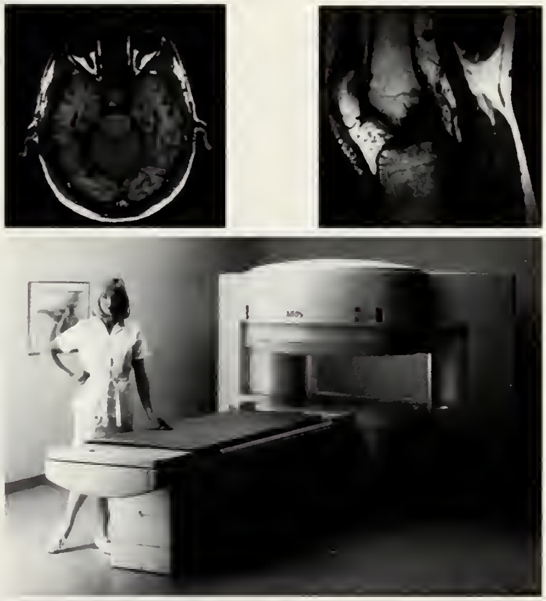

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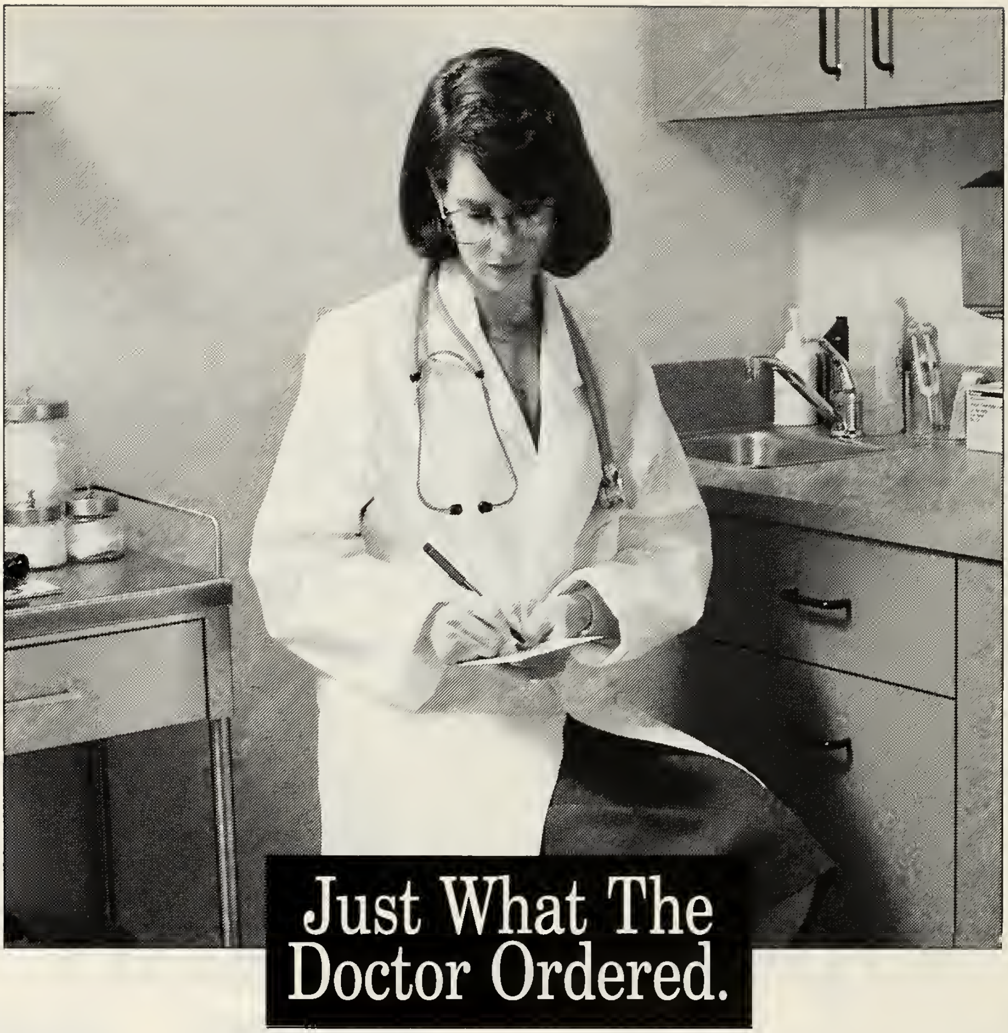
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Sticks and Stones Can Break My Bones, But Words Can Never Hurt Me

Noah Hillman
University of Missouri-Columbia

The following manuscript is the winner of the MSMA medical student essay contest. Along with publication in *Missouri Medicine*, Mr. Hillman will receive $100.

As the anger built inside my mind and I fought off the tears, I repeated this line a few times out loud. No matter what Johny said, I would be strong. I had been taught this saying as a barrier against the harsh words said by my peers on the playground. It has been taught to children for generations and probably will continue to be used long after I have left this world. It is used because it works and children feel better. It is just a shame that the saying is not entirely true.

This saying works for the mean words of a nine-year-old, but these are not the words which really hurt a child. The words that cut through their hearts and tear at their self-esteems do not come from their enemies. They come from the ones they love the most and the ones they treasure every minute with. It is easy and natural to attribute bad behaviors and thoughts to people you do not like. It is harder for a child to rationalize why a parent or friend would say such harsh things.

It would be to simple to say a person should not yell at their children and tell them they are stupid. Most rational, educated adults know this is not a means of building a child's feelings of self worth. So if these parents are not yelling at their children, why do we see children who go through life without much self-esteem. Why do we constantly find straight A students with no feelings of accomplishment? Why does the head cheerleader insist on not eating for months? Why does the "all-American kid" think about running away or even worse?

The answer is found in one word – love. This word has a million meanings. For the children listed above, it does not include loving themselves. One must ask themselves how these children, who accomplish anything they want, do not love themselves. People might be quick to look for a troubled home life. But often this is not the case. They come from solid family structures and they come from families in crisis. They come from single family homes and those with extended families. These children can be found in all social classes and religions. The thing which ties them together is these children have grown up without a love for themselves.

Since these children do not love themselves, we should look to children who do for clues to the latter's problems. I believe these children were given a few extra items to put in their tool belts. They were told they were loved. They were shown their environment was safe and they did not have to worry. They were held when they wanted to cry. They were answered, no matter how many questions they asked. They were encouraged to try and comforted when they failed. But when they succeeded, they were told they had done well.

I met a young man once who was determined to conquer the world. When I began to question why he needed to accomplish such a great goal, he said then he would be happy. This caught me off guard. I looked at the man, who I knew had accomplished many a task, and asked if he was not happy. He said he was not sad, but was waiting for the joy of his final goal. For me, he was a train heading full steam into the future; never stopping to pick up passengers. He did not know what it was to be truly satisfied. He did not know the joy of accomplishing things. For him, the world was a long line of things to do. Although I had barely met this man, I knew his story very well. He was like many of the "over-achievers" I have met. He was pushed at a young age to accomplish everything, but he was never taught what was good enough. It was not until I, a perfect stranger, mentioned that he had accomplished a lot that he actually looked back at what he had done. It was not until he met someone, who was not close to him and was impressed by him, that he stopped. I have kept in close contact with him, and I can say he is now truly happy.

What the man in the previous story needed was love. He needed to love himself. I once heard a professor preach about how to raise children. He said that he had always wondered himself, so he asked an old professor. The professor smiled and said that he had programmed his children. He had constantly told his children they were smart, funny, good children and everyone liked them. By the time he had repeated this phrase a hundred times, his children had it instilled in their brains.

Some might say he brainwashed his children, and they would be right. But he also gave them a gift which would last a lifetime; a love for themselves. Although his system was very calculated, it shows one major principle; children need to be loved and constantly reminded of this love. Children need to know on a daily basis their parents care for them and are proud of their accomplishments. In a way, we must brainwash them.

The man who wanted to capture the world was never happy. His goals were so great that the steps toward them gave him no pleasure. I have no question this young man will one day reach his goals and I am happy to see he is now happy. In a way, I must have brainwashed him.

We need to realize the true meaning of words. It is often the silence that hurts more. It is the silence after completing a task that makes the task incomplete. Children, and humans as a whole, need to hear praise when they do something good as much as punishment when they do something bad. Two bad things come from not hearing praise: 1) you act up because you need some form of attention or 2) you continue like a train through the night; accomplishing things but never being happy. I am not sure which one is worse. I would vote for the latter. MoMed

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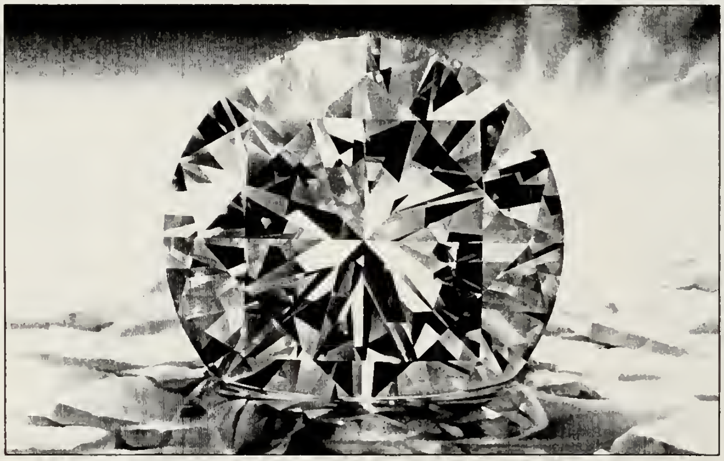

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ANNUAL MEETING AND EVENTS

For your convenience, the MSMA Annual Meetings and Events are listed on pages 6 and 7. MSMA members and guests are welcome to any and all meetings and events. Please plan to join us at the scheduled events. For further information, please contact the MSMA staff, Convention Registration, Grand Ballroom Foyer.

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Gary Dyer, MD, *St. Joseph*
James Wolfe, MD, *Springfield*
Mr. Kamran Chaudhary, *Kansas City*

MSMA

Extra Membership Pins Available in Exhibit Hall

MSMA members can now purchase additional membership pins - one pin for a badge, one for a lab coat, and one for special occasions - at the MSMA Booth in the Exhibit Hall for $5 each.

Make check payable to MSMA.

Annual Meetings and Events

Thursday, April 8, 1999

7:00-9:30 am	Moneta Breakfast, *Rooms 72-73*
10:00-Noon	Opening Session, MSMA House of Delegates, *Salon B*
11:45-1:00 pm	St. Louis Metropolitan Medical Society Luncheon Caucus, *Parasol I*
Noon-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon Caucus, *Rooms 70-71*
1:30 pm	MSMA Reference Committee Meetings Reference Committee A, *Salon C* Reference Committee B, *Rooms 60-61*

Friday, April 9, 1999

7:00-8:30 am	Breakfast Meetings District #1 Breakfast, *Room 74* District #2 Breakfast, *Room 76* District #5 Breakfast, *Room 71* District #6 Breakfast, *Room 73* District #8 Breakfast, *Room 72* District #9 Breakfast, *Room 77* District #10 Breakfast, *Room 75*
7:30-9:00 am	University of Missouri-Columbia Alumni Organization Board of Governors' Breakfast Meeting, *Rooms 60-61*
9:00-10:30 am	MSMA General Session, *Salon B* (see page 12)
11:00-12:30 pm	MSMA General Session, *Salon B* (see page 7)
11:00-1:00 pm	Medical Student Delegate Luncheon, *Room 75*
11:45-1:00 pm	Missouri State Medical Foundation Business Meeting, *Room 74*
Noon-1:00 pm	Metropolitan Medical Society of Greater Kansas City Luncheon, *Parasol I*
Noon-2:00 pm	MSMA/MSMAA General Session and Luncheon, *Salon A* (see page 10)
12:30-2:00 pm	University of Missouri-Columbia Alumni Awards Luncheon, *Crystal Ballroom*
1:00-2:00 pm	MSMA Organized Medical Staff Section Business Session, *Room 70*
1:30-4:00 pm	MSMA General Session, *Parasol II* (see page 8)
2:00-3:00 pm	MSMA General Session, *Salon C* (see page 11)
2:00-4:00 pm	St. Louis Metropolitan Medical Society Caucus, *Rooms 72-73*

ANNUAL MEETINGS AND EVENTS

Friday *(continued)*

4:00-6:00 pm	Second Session, MSMA House of Delegates, *Salon B*
6:00-7:30 pm	University of Missouri-Columbia School of Medicine Alumni Reception, *Salon A*
	University of Missouri-Kansas City School of Medicine Alumni Reception, *Room 63*
	Washington University School of Medicine Alumni Reception, *Rooms 60-61*
	St. Louis University School of Medicine Alumni Reception, *Salon C*
7:30-11:00 pm	AMA Foundation Benefit, *Parasol I-II*

SATURDAY, APRIL 10, 1999

7:00-8:00 am	MSMA Section on Young Physicians Program, *Room 64*
	International Medical Graduate Program, *Room 62*
8:00-Noon	MSMA General Session, *Salon B* (see page 9)
11:00-Noon	MMPAC Meeting, *Room 77*
1:00-2:00 pm	Open Forum on AMA Issues, *Salon C*
6:30-7:30 pm	MSMA Presidential Inauguration, *Salon B*
7:30-9:00 pm	MSMA Reception, *Salon C*

SUNDAY, APRIL 11, 1999

7:30-9:00 am	Final Session, MSMA House of Delegates Breakfast Meeting, *Salon A*

Practical Tips on How You Can Survive

Y2K

Friday, April 9
11:00 am - 12:30 pm
Salon B

Presented by:
Eugene R. Worth, MD, MEd
President, Medical Information Technologies, Inc.
Columbia
1.5 Hours Category 1 Credit, 1.5 Hours Prescribed Credit

Christian Medical & Dental Society

Sunday, April 11 9:30-11:30 am Scientific Program, *Rooms 63-64*

Scientific Program
(sponsored by the Christian Medical & Dental Society)
2 hours Category 1 credit

Moderator: Richard Heimburger, MD

9:30 am
Clinical Spirituality
Robert Potter, MD
(followed by question/answer session)

10:10 am
Making our Communities More Family Friendly
Warren Lovinger, MD
(followed by question/answer session)

10:50 am
Short Term Overseas Medical Missions
Richard Heimburger, MD
(followed by question/answer session)

Objectives: Following this educational offering, participants should have a better understanding of: 1) A Judeo-Christian viewpoint on ethical, socio-economics, emotional and spiritual values in healing and caring in medical practice; 2) Mechanisms to strengthen family, children and adolescent relationships; and 3) Opportunities for short-term service and cross cultural teaching in the third world countries.

Needs: Member needs assessment prioritized the following areas essential to the emotional and spiritual values in the healing and caring of a physician's practice: 1) Emotional and spiritual counseling in the office setting; 2) Strengthening the family through your practice; 3) Delivery of International Health Care: Preparation for Short Term Service Overseas.

Building Bridges:
Enhancing the Physician-Patient Partnership

Friday, April 9 • 1:30 - 4:00 pm

Parasol II

Presented by
Eric W. Jacobson, MD, reviewer of the nationwide medical education offering,
"Building the Physician-Patient Partnership."

This two and a half hour interactive workshop is designed to enhance the physician-patient partnership and improve physicians' communication skills. The outcomes of this partnership include: enhanced patient satisfaction, increased patient compliance, and improved clinical outcomes. The workshop incorporates didactic material, role playing, interactive exercises and video demonstrated right way/wrong way physician behavior.

2.5 Hours Category 1, 2.5 Hours Prescribed Credit
Unrestricted grant provided by Glaxo Wellcome

Missouri Dermatological Society

Friday, April 9 11:00-12:30 pm Scientific Program, *Rooms 62-63*

Scientific Program
(by the Missouri Dermatological Society)
1.5 Hours Category 1, 1.5 Hours Prescribed Credit

Moderator: Susan Ailor, MD

11:00-12:30 pm
Dermatology for the Non-Dermatologist
Susan K. Ailor, MD

Objectives: After attending this program, participants should be able to identify, diagnose and treat some common dermatoses that the primary care physician and dermatologist might encounter in his/her practice.

Needs: This educational activity was selected as a result of physicians' comments obtained on program evaluations.

MISSOURI CHAPTER, AMERICAN COLLEGE OF EMERGENCY MEDICINE

MISSOURI PSYCHIATRIC ASSOCIATION

MISSOURI SECTION, AMERICAN COLLEGE OF OB-GYN

Saturday, April 10 1:00-5:00 pm Scientific Program, *Room 60*

Scientific Program
(sponsored by Missouri Chapter, American College of Emergency Medicine, Missouri Psychiatric Association, and the Missouri Section, American College of Ob-Gyn)
4 hours Category 1, 4 Hours Prescribed Credit

Moderator: Howard Peth, Jr., MD

Medicine and the Law: Mini-Conference on the Federal EMTALA/COBRA Regulations

1:00 pm
The Basics of the EMTALA/COBRA Provisions
Howard A. Peth, Jr., MD

2:00 pm
Mechanics of the HCFA Investigation: What They Look For and How to Respond
Mitchele Rezinicek, RN, JD

3:00 pm
The HCFA Medical Review: Where There's Smoke There's Fire
Ronald P. Rae, MD

4:00 pm
Informed Consent: Transfer Requests and Treatment Refusals Emergency Management of the Difficult Patient
Howard A. Peth, Jr., MD

Objectives: At the conclusion of this mini-conference, the participants will be able to: 1) State the legal requirements involved in patient transfers, 2) Define the terms patient transfer, medical screening examination, and stabilization, 3) Explain the emergency consent theory and how to evaluate a patient's capacity to give consent, 4) Understand the procedures employed by US federal and State of Missouri regulatory authorities in conducting investigations into alleged EMTALA violations, 5) Discuss the scope of sanctions available to HCFA in enforcing alleged EMTALA/COBRA violations, 6) Implement an effective EMTALA compliance program at your hospital, and 7) Understand how to respond to HCFA investigation into alleged EMTALA/COBRA violations.

Needs: Program content was selected from physician's comments obtained from previous program evaluations. Due to an increased number of EMTALA-related investigations, this educational activity is designed to ensure compliance with EMTALA/COBRA regulations to avoid catastrophic sanctions.

Anatomy of a Contract

Saturday, April 10 • 8:00 - Noon
Salon B

8:00-10:00 am
Anatomy of a Contract
Presented by Randy S. Gerber, Attorney

10:00-Noon
Innovative Developments in Electronic Medical Records (EMRs)
Presented by Eugene R. Worth, MD
EMRs are the record of the future. Participants will have better understanding of the basics of electronic medical records, physician workflow patterns and innovative EMRs of the future.

E-mail: Physicians and Patients
Presented by Eugene R. Worth, MD
Participants will obtain an overview of physician's use of e-mail - physician to physician and physician to patient.

4 Hours Category 1, 4 Hours Prescribed Credit

MISSOURI SOCIETY OF EYE PHYSICIANS AND SURGEONS

Saturday, April 10	7:30-Noon	Scientific Program, *Crystal Ballroom*
	1:00-4:00 pm	Scientific Program, *Crystal Ballroom*

Scientific Program
(sponsored by the Missouri Society of Eye Physicians and Surgeons)
7.5 Hours Category 1, 7.5 Hours Prescribed Credit

Moderator: Thomas Whittaker, MD

8:30 am
MoSEPS Roundtable - Open Discussion

9:00 am
The Impact of Medical Record Documentation and Coding on Patient Care
Ms. Joy Newby

10:20 am
Ciliary Body Ablation: Has Its Time Come?
Dan Schoenleber, MD
Oculopharyngeal Dystrophy in Mid-Missouri
Ken Knudtson, MD
LASIK vs. PRK: Which is Better, What is Best?
John W. Cowden, MD
Eli Lilly Multicenter Study on the Effects of Protein Kinase CB-Inhibitor on Diabetic Retinopathy
L. David Ormerod, MD

Objectives: Following the educational offering, participants will have a better understanding of: 1) Current opinions and research on ocular and systemic inflammatory disease with emphasis on diagnostic and treatment options; 2) Current controversies in ophthalmic subspecialties including glaucoma, retina, anterior segment and refractive surgery, and 3) Current practice modalities and their impact on patient care.

Needs: The procedures utilized to determine physician needs and interests were: 1) Annual survey of membership which includes questions concerning topics members would like to see in a scientific program, 2) Board of Directors discussion of possible program topics based on their own experiences and discussions with colleagues back home, 3) Review of AAO annual meeting and other ophthalmology society programs, and 4) Review of current journals.

1:00 pm
Ocular Problems in Diabetes Mellitus
Stephen S. Feman, MD

1:45 pm
What's New in Refractive Surgery
Steve Fox, MD

2:45 pm
Principles of Risk Management in the Ophthalmologist's Office
Paul Weber, JD

Other Activities
(sponsored by the Missouri Society of Eye Physicians and Surgeons)

Friday
6:00 pm
Board of Directors Dinner Meeting, *Room 62*

Saturday
7:30 am
Breakfast with Meeting, *Crystal Ballroom*
12:00 noon
Luncheon, *Crystal Ballroom*

Domestic Violence:
Recognition, Intervention and Documentation

Friday, April 9 ◆ Noon - 2:00 pm
Salon A

Presented by: Zita Surprenant, MD, Lenexa, Kansas
A Joint Luncheon and Scientific Program
sponsored by the Missouri State Medical Association and Alliance.

1.5 Hours Category 1, 1.5 Hours Prescribed Credit

Missouri Academy of Family Physicians

Saturday, April 10 10:15-12:30 pm Scientific Program, *Room 60*

Scientific Program
(Missouri Academy of Family Physicians)
2 Hours Category 1, 2 Hours Prescribed Credit

Moderator: Lawrence Rues, MD

10:15 am
Coding/Documentation Headaches and Remedies for 1999. Evaluation/Management Code Documentation Update.
Ms. Lisa Norr

Objectives: Following the scientific program, participants will have a better understanding of: 1) How to reduce your risk of audit; 2) 1999 changes to E/M Codes and Documentation; 3) Common problems and solutions of documentation; 4) Procedures to develop a medical record compliance program; and 5) AMA and HCFA update.

Needs: This requested educational offering is designed to provide physicians with an update on significant revision to Evaluation/Management Code Documentation Guidelines.

Missouri State Neurological Association

Saturday, April 10 9:00-10:30 am Scientific Program, *Room 73*

Scientific Program
(Missouri State Neurological Association)
1.5 Hours Category 1, 1.5 Hours Prescribed Credit

Moderator: Joseph Hanaway, MD

9:00 am
Advances in the Treatment of Epilepsy and Parkinson's Disease
Joseph Hanaway, MD

Objectives: After attending this educational offering, participants will have a better understanding of new and emerging treatment options for the neurology patient regarding Epilepsy and Parkinson's Disease.

Needs: Member comments and participant evaluations were utilized to select this educational activity.

How to Protect Yourself & Your Practice: An Update on Controlled Substance Issues

Friday, April 9 ◆ 2:00 - 3:30 pm
Salon C

Presented by: Dan Crider, RPh
Missouri Bureau of Narcotics and Dangerous Drugs

1.5 Hours Category 1, 1.5 Hours Prescribed Credit

MISSOURI SOCIETY OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY

Friday, April 9	11:00-12:30 pm, 1:00-2:00 pm	Scientific Program, *Rooms 60-61*
Saturday, April 10	9:15-Noon	Scientific Program, *Room 62*

Scientific Program
(Missouri Society of Otolaryngology - Head and Neck Surgery)
6 Hours Category 1, 6 Hours Prescribed Credit

Moderator: Greg Renner, MD

Friday
11:00-12:30 pm
The Diagnosis and Treatment of Obstructive Sleep Apnea
Jerry Templer, MD
1:00-2:00 pm
Identification and Management of Cutaneous Lesions of the Head and Neck
Greg Renner, MD
Saturday
9:15 am
Somnoplasty Using a Radiofrequency Needle
William Davis, MD
9:25 am **Management of Retropharyngeal Abscess in Children**
Daniel J. Kirse, MD
9:35 am **New Concepts in Treatment of Differentiated Thyroid Cancer**
Robert Zitsch, MD
9:55 am **Management of the Aging Brow**
J. David Kriet, MD
10:05 am **Endoscopice Forehead/Brown Lifting**
Keith Laferriere, MD

Objectives: Following the scientific program, participants will have a better understanding of: 1) Pediatric sleep apnea and localization of the obstruction and proper examination of aerodigestive tracts, 2) Early recognition, treatment and prevention of obstructive sleep apnea, 3) Conditions associated with both central and obstructive apnea, 4) Sciences involved in sleep and the relationship of Obstructive Sleep Apnea Syndrome, 5) Early recognition and treatment of basal, squamous and melanomatous lesions, and 6) Principles and methods of treatment of all aspects of skin cancer of the head and neck for family physicians and internists.

Needs: Participant evaluation and member requests have been instrumental in developing this educational activity on sleep apnea, head and neck lesions, diseases of the ear and surgical options for chronic sinusitis and cancer of the throat.

10:15 am **Neurolaryngology Update**
Albert L. Merati, MD
10:35 am **A System for Intraoperative Monitoring of the Facial and Recurrent Laryngeal Nerves**
J. Lee Rea, MD
10:45 am **ENT Complications of GERD in Kids**
Pam Nicklaus, MD
10:55 am **Update in Otolaryngic Allergy**
Laurie Fowler, MD
11:55 am **Troubles with Tubes - Tympanostomy Update 1999**
Richard Chole, MD

12:30-1:15 pm
Management of Petrous Apicitis
Richard Chole, MD

Other Activities
(sponsored by the Missouri Society of Otolaryngology - Head and Neck Surgery)

Saturday
7:00-9:00 am
Business and Breakfast Meeting, *Room 72*
12:30 pm
Luncheon with Program, *Room 64*

Preserving the Physician-Patient Relationship in a Managed Care Environment

presented by Eric Jacobson, MD

Impact of Managed Care on the Physician-Patient Relationship

presented by K. Lynne Moritz, MD

Friday, April 9 • 9:00 - 10:30 am, Salon B

1.5 Hours Category 1, 1.5 Hours Prescribed Credit

MISSOURI CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Friday, April 9	1:00-4:00 pm	Scientific Program, *Room 71*
Saturday, April 10	1:00-4:00 pm	Scientific Program, *Room 63*

Scientific Program
(Missouri Chapter, American Academy of Pediatrics)
6 Hours Category 1, 6 Hours Prescribed Credit

Moderator: Bernard Griesemer, MD

Friday
1:00-4:00 pm
STD's in Schools
Bernard A. Griesemer, MD
Media Literacy - What is the Media Teaching our Kids?
Bernard A. Griesemer, MD
School Health: It's Not Just Condoms and Cough Drops Anymore
Daryl Lynch, MD
Firearms Prevention
Denise Dowd, MD

Objectives: After attending this educational activity, participants will have a better understanding of health issues in today's school system and the importance of physician involvement.

Needs: Academy members' input was utilized to design this program to raise the level of awareness among physicians regarding school health issues today.

Saturday
1:00-4:00 pm
Same as Friday's program, co-sponsored by the Missouri State Medical Association Alliance.

Other Activities
(sponsored by the Missouri Chapter, American Academy of Pediatrics)

Friday
5:00-6:30 pm
Reception for AAP Members, *Academy Suite*
Saturday
11:30 am
Luncheon Business Meeting, *Drawing Room Terrace*

MISSOURI ASSOCIATION OF PLASTIC AND RECONSTRUCTIVE SURGEONS

Saturday, April 10 8:00-11:30 am, 1:00-4:00 pm Scientific Program, *Room 61*

Scientific Program
(Missouri Association of Plastic and Reconstructive Surgeons)
6.5 Hours Category 1, 6.5 Hours Prescribed Credit

Moderators: Meredith Payne, MD and Richard Heimburger, MD

8:00-11:30 am
Plastic Surgical Workforce - Too Many or Too Few?
Mary McGrath, MD
1:00 pm
Plastic Surgery Update
Dealing with Emerging Surgical Technology
Mary McGrath, MD
1:45 pm **Results of and Indications for Preservation of Breast Implants**
Leroy Young, MD
2:30 pm **Implications for Replantation - Are We Doing Too Many?**
Kerri Woodberry, MD
3:15 pm **Tattoo Removal in Gang Members - An Aid in Rehabilitation**
Edmond Cabbabe, MD

Objectives: After attending this program, participants will have a better understanding of: 1) Problems inherent in the current training programs; 2) Effective utilization of new and emerging technology; and 3) Innovative surgical techniques.

Needs: Participant evaluations were instrumental in developing this educational offering for plastic and reconstructive surgeons.

Other Activities
(sponsored by the Missouri Association of Plastic and Reconstructive Surgeons)

Saturday
7:00-8:00 am
Breakfast Business Meeting, *Room 77*
11:30-1:00 pm
Luncheon, *Room 73*

MISSOURI RADIOLOGIC SOCIETY

Saturday, April 10 1:00-4:00 pm Scientific Program, *Room 62*

Scientific Program
(sponsored by the Missouri Radiologic Society)
3 Hours Category 1, 3 Hours Prescribed Credit

1:00 pm
ACR Compliance Program Guidelines
Thomas R. Hoffman, MD

2:00 pm
Medicine and the Information Superhighway
John Oro, MD

3:00 pm
Missouri Healthcare Legislation
Harvey Tettlebaum, Esq.

Objectives: After this program, participants will have a better understanding of: 1) Principles of a compliance program and how this may be implemented, 2) How medicine is using the information superhighway, and 3) The impact of Missouri legislation on patient care.

Needs: Participant evaluations along with suggestions from Society members were utilized to form this educational activity.

Other Activities
(sponsored by the Missouri Radiologic Society)

Saturday
8:00-10:00 am
Breakfast, *Parasol II*
Noon
Luncheon Meeting, *Room 72*

MISSOURI STATE SURGICAL SOCIETY

MISSOURI CHAPTER, AMERICAN COLLEGE OF SURGEONS

AMERICAN CANCER SOCIETY, HEARTLAND DIVISION

Friday, April 9 1:30-3:00 pm Scientific Program, *Rooms 62-63*
Saturday, April 10 9:00-11:30 am Scientific Program, *Room 63*

Scientific Program
(sponsored by the Missouri State Surgical Society; Missouri Chapter, American College of Surgeons; and the American Cancer Society, Heartland Division)
5.5 Hours Category 1, 5.5 Hours Prescribed Credit

Moderators: Ann Peick, MD; Michael Bukstein, MD; and David Ora, MD

Friday
1:30 pm
TBA
Charles W. Van Way, MD

Objectives: After attending this educational offering, participants will have a better understanding of: 1) Socioeconomic trends impacting surgery; 2) Surgical considerations for skin grafts; and 3) Current treatment options for breast cancer.

Needs: Program content was determined by physicians' comments on the 1998 Annual Convention participant evaluations.

Saturday
9:00-11:30
Full Thickness Skin Graft Using Extremities of Ellipse as Donor
Max A. Heeb, MD
Noon
Prevention Trials for Breast Cancer
Steven B. Standiford, MD

Other Activities
(sponsored by the Missouri State Surgical Society; Missouri Chapter, American College of Surgeons; and the American Cancer Society, Heartland Division)

Saturday
Noon
Cancer Liaison Luncheon, *Salon A*

Chronological Listing of Meetings

THURSDAY, APRIL 8, 1999

7:00-4:00 pm	**MSMA** Registration, *Grand Ballroom Foyer*
7:00-9:30 am	**Moneta** Breakfast, *Rooms 72-73*
10:00-Noon	Opening Session **MSMA** House of Delegates, *Salon B*
11:45-1:00 pm	**St. Louis Metropolitan Medical Society** Luncheon Caucus, *Parasol I*
Noon-1:00 pm	**Metropolitan Medical Society of Greater Kansas City** Luncheon Caucus, *Rooms 70-71*
1:30 pm	**MSMA** Reference Committee Meetings
	Reference Committee A, *Salon C*
	Reference Committee B, *Rooms 60-61*
4:00-6:00 pm	**MSMAA** Registration, *Grand Ballroom Foyer*
7:00 pm	**MSMAA** Dutch Treat Dinner, *J. B. Hooks*

FRIDAY, APRIL 9, 1999

7:00-4:00 pm	**MSMA** Registration, *Grand Ballroom Foyer*
7:00-8:30 am	Breakfast Meetings
	Districts #1, *Room 74*
	District #2, *Room 76*
	District #5, *Room 71*
	District #6, *Room 73*
	District #8, *Room 72*
	District #9, *Room 77*
	District #10, *Room 75*
7:00-8:30 am	**Missouri Physicians Health Committee** Breakfast Meeting, *Room 70*
7:30-8:30 am	**MSMAA** Continental Breakfast, *Windgate Hall*
7:30-9:00 am	**UMC** Alumni Organization Board of Governors Breakfast Meeting, *Rooms 60-61*
7:30-Noon	**MSMAA** Registration, *Salon C*
8:30-11:30 am	**MSMAA** General Assembly, *Salon C*
9:00-10:30 am	**MSMA** General Session, *Salon B* (see page 12)
11:00-12:30 pm	**Missouri Society of Otolaryngology - Head and Neck Surgery** Scientific Presentation, *Rooms 60-61*
11:00-12:30 pm	**Missouri Dermatological Society, Inc.** Scientific Presentation, *Rooms 62-63*
11:00-12:30 pm	**MSMA** General Session, *Salon B* (see page 7)
11:00-1:00 pm	**Medical Student Delegate** Luncheon, *Room 75*
11:45-1:00 pm	**Missouri State Medical Foundation** Business Meeting, *Room 74*
Noon-1:00 pm	**Metropolitan Medical Society of Greater Kansas City** Luncheon, *Parasol I*
Noon-2:00 pm	**MSMA/Alliance** General Session and Luncheon, *Salon A* (see page 10)
12:30-2:00 pm	**UMC** Alumni Luncheon, *Crystal Ballroom*
1:00-2:00 pm	**Missouri Society of Otolaryngology-Head and Neck Surgery** Scientific Presentation, *Room 60-61*
1:00-2:00 pm	**MSMA Organized Medical Staff Section** Business Session, *Room 70*
1:00-4:00 pm	**Missouri Chapter, American Academy of Pediatrics** Scientific Presentation, *Room 71*
1:30-3:00 pm	**Missouri State Surgical Society** Scientific Presentation, *Rooms 62-63*
1:30-4:00 pm	**MSMA** General Session, *Parasol II* (see page 9)
2:00-3:30 pm	**MSMA** General Session, *Salon C* (see page 11)

Chronological Listing

2:00-4:00 pm	**St. Louis Metropolitan Medical Society** Caucus. *Rooms 72-73*
4:00-6:00 pm	Second Session **MSMA** House of Delegates. *Salon B*
5:00-6:30 pm	**Missouri Chapter, American Academy of Pediatrics** Reception. *Academy Suite*
6:00 pm	**Missouri Society of Eye Physicians and Surgeons** Board of Directors Dinner Meeting. *Room 62*
6:00-7:30 pm	Alumni Receptions
	University of Missouri-Kansas City. *Room 63*
	Washington University School of Medicine. *Rooms 60-61*
	University of Missouri-Columbia. *Salon A*
	St. Louis University School of Medicine. *Salon C*
7:30-11:00 pm	**AMA Foundation** Fundraiser. *Parasol I-II*

Saturday, April 10, 1999

7:00-2:00 pm	**MSMA** Registration. *Grand Ballroom Foyer*
7:00-8:00 am	**Missouri Association of Plastic and Reconstructive Surgeons** Breakfast Meeting. *Room 77*
7:00-9:00 am	**Missouri Society of Otolaryngology-Head and Neck Surgery** Breakfast Business Meeting. *Room 72*
7:00 am	**MSMAA** Past Presidents Breakfast. *Parasol I*
7:30-8:15 am	**Missouri Society of Eye Physicians and Surgeons** Breakfast Meeting. *Crystal Ballroom*
8:00-10:00 am	**MSMAA** Registration. *Salon C*
8:00-10:00 am	**Missouri Radiologic Society** Breakfast. *Parasol II*
8:00-11:30 am	**Missouri Association of Plastic and Reconstructive Surgeons** Scientific Presentation. *Room 61*
8:00-Noon	**MSMA** General Session. *Salon B* (see page 8)
8:00-Noon	**MSMA Section on Young Physicians/International Medical Graduate** Program. *Salon B*
8:30-Noon	**Missouri Society of Eye Physicians and Surgeons** Scientific Presentation. *Crystal Ballroom*
8:30-Noon	**MSMAA** General Assembly Second Session. *Salon C*
9:00-10:30 am	**Missouri State Neurological Association** Scientific Presentation. *Room 73*
9:00-11:30 am	**Missouri State Surgical Society** Scientific Presentation. *Room 63*
9:15-Noon	**Missouri Society of Otolaryngology-Head and Neck Surgery** Scientific Presentation. *Room 62*
10:15-12:30 pm	**Missouri Academy of Family Physicians** Scientific Presentation. *Room 60*
11:00-Noon	**MMPAC** Meeting. *Room 77*
11:30 am	**Missouri Chapter, American Academy of Pediatrics** Luncheon Business Meeting. *Drawing Room Terr.*
11:30 am	**Missouri Association of Plastic and Reconstructive Surgeons** Luncheon. *Room 73*
Noon	**MSMAA** Installation-Awards Luncheon. *Parasol I*
Noon	**Missouri Society of Eye Physicians and Surgeons** Luncheon. *Crystal Ballroom*
Noon	**Missouri Radiologic Society** Luncheon. *Room 72*
Noon	**American Cancer Society, Heartland Division** Luncheon. *Salon A*
12:30 pm	**Missouri Society of Otolaryngology-Head and Neck Surgery** Luncheon. *Room 64*
1:00-4:00 pm	**Missouri Association of Plastic and Reconstructive Surgeons** Scientific Presentation. *Room 61*
1:00-2:00 pm	Open Forum on **AMA** Issues. *Salon C*
1:00-4:00 pm	**Missouri Radiological Society** Scientific Presentation. *Room 62*
1:00-4:00 pm	**Missouri Society of Eye Physicians and Surgeons** Scientific Presentation. *Crystal Ballroom*
1:00-4:00 pm	**Missouri Chapter, American Academy of Pediatrics, MSMAA** Scientific Presentation. *Room 63*
1:00-5:00 pm	**Missouri Chapter, American College of Emergency Physicians; Missouri Psychiatric Association;** and the **Missouri Section, American College of Ob-Gyn** Mini-Conference Presentation. *Room 60*

Chronological Listing

Saturday *(continued)*

3:00 pm	**MSMAA** Joint Convention Board Meeting, *Parasol II*
6:30-7:30 pm	**MSMA** Presidential Inauguration, *Salon B*
7:30-9:00 pm	**MSMA/MSMAA** Presidential Reception, *Salon C*

Sunday, April 11, 1999

7:30-9:00 am	Final Session **MSMA** House of Delegates, *Salon A*
9:30-11:30 am	**Christian Medical and Dental Society** Scientific Presentation, *Rooms 63-64*

Your Presence is Requested

All MSMA members and guests are invited to attend the
MSMA Presidential Inauguration,
Saturday, April 10, 1999
6:30-7:30 pm,
Salon B.

Ceremonies include inaugurating
MSMA's 141st President, William Dorzab, MD, of Raytown,
presenting the 50-Year Physician Pins,
and recognizing past presidents and component medical societies.

After the ceremony,
please join Dr. Dorzab and his spouse, Linda Dorzab, MD
and the
1999-2000 MSMA Alliance President Beverly Murrell and spouse H. Jerry Murrell, MD
in Salon C for a Presidential Reception.

We will also be honoring the
Immediate Past Presidents of the MSMA, Stephen Vilmer, MD
and of the Alliance, Mrs. Judy Corry.

MISSOURI STATE MEDICAL ASSOCIATION
1999 HOUSE OF DELEGATES
ORDER OF BUSINESS

1ST SESSION, THURSDAY, APRIL 8, 1999, 10:00 AM, SALON B

Call to Order
Invocation
Preliminary Report, Committee on Credentials
Minutes of Previous Meeting (Published in *Missouri Medicine*, June 1998)
Speaker's Instructions and Appointments of Reference Committees
President's Message - **Stephen Vilmer, MD**
Report of the Secretary - **James Wolfe, MD**
Report of the Treasurer - **Edmond Cabbabe, MD**
Report of the Executive Vice President - **C.C. Swarens**
Report of the President of the MSMA Alliance - **Mrs. Judy Corry**
Reports of the Standing Committees and Commissions
Appointment of Committee on Nominations
Unfinished Business
New Business

Constitution and Bylaws
Arteso Raborar, MD, *Springfield*

Physician's Health
Thomas Anderson, MD, *Columbia*

Planning
Herluf Lund, Jr., MD, *Chesterfield*

Publications
J. Regan Thomas, MD, *St. Louis*

Continuing Medical and Health Manpower
David Martin, MD, *Chesterfield*

Interspecialty Medicine
Mark Martin, MD, *Lee's Summit*

Legislative Affairs
Jerry Kennett, MD, *Columbia*

Medical Economics, Third Party Medicine and Governmental Relations
Jeffrey Copeland, MD, *St. Peters*

Medical-Legal Affairs
Ted Groshong, MD, *Columbia*

Public Affairs
James Blaine, MD, *Springfield*

Report of the Council
(This includes reports of
Council Ad-Hoc Committees)
Gordon Goldman, MD, *St. Louis*

Council on Ethical and Judicial Affairs
Hugh E. Stephenson, Jr., MD, *Columbia*

2ND SESSION, FRIDAY, APRIL 9, 1999, 4:00 PM, SALON B

Call to Order
Supplemental Report of the Committee on Credentials
Report of the Nominating Committee
Reports of the Reference Committees
New Business

FINAL SESSION, SUNDAY, APRIL 11, 1999, 7:30 AM, SALON B

Call to Order
Report of the Committee on Credentials
Election of Officers
Report of Elections of Councilors
Reports of Reference Committees
Unfinished Business
New Business
Installation of Officers
President's Appointment of Committee and Commission Chairs
Selection of Location of Next Annual Convention

Instructions for Delegates

Each delegate elected to the House of Delegates by their component medical society will receive a "delegate's credentials" card, supplied by their component medical society. In the event the elected delegate is unable to be present at the Annual Convention, their duly elected alternate will then be entitled to register as a delegate.

Delegates should present their delegate's credentials card at the time of registration. The delegate will then receive the Delegate's badge and the credentials card will be turned over to the Credentials Committee for its report to the House.

The registration desk will be open at 7:00 am, Thursday, April 8, 1999, Grand Ballroom Foyer. Delegates are urged to register as early as possible so that they may be seated promptly when the House is called to order at 10:00 am. The registration desk will remain open during meeting hours throughout the Annual Convention.

For Information

Proceedings of the House of Delegates are conducted in accordance with Davis' Rules of Order.

In addition to the copies provided for the delegates, ten copies of each resolution introduced from the floor MUST be prepared and delivered to the Secretary at the time of its introduction. Typists will be available through the MSMA registration desk.

All members of the MSMA are privileged and urged to attend the sessions of the House of Delegates and meetings of the Reference Committees. While discussion in the House is limited to duly seated delegates, committee chairs and officers, any Association member may present their viewpoint during meetings of Reference Committees when recognized by the Chair.

DELEGATES AND ALTERNATES* TO THE 1999 ANNUAL CONVENTION

First District

Buchanan

James Conant
Robert LacKamp
Bruce Smith
Merlin Brown*
Scott Wade*

Clay-Platte

Patrick E. McGregor
James P. Reardon
Stephen A. McCray
Frederick E. Thompson
James L. Stewart

Second District

North Central

Ron Phillips

Northeast Missouri

Sandra Ahlum
Michael Bukstein
Jeffry Evans
Stephen Halpin
Brett Hosley, DO
Lent Johnson
Erik Meidl

Third District

St. Louis

Erol Amon
Donald Arnold
Craig Aubuchon
Sean Bailey
Chelmer Barrow, DO
Jose A. Benitez
Gregg J. Berdy
Grant A. Bever
Arjun Bhattacharya
Richard Biek
Lawrence Billy
George Bohigian
Robert Bonsanti
Arnold G. Brody
Edmond B. Cabbabe
David C. Campbell
Michael J. Chehval
John E. Codd
David H. Cort
Patrick Coyne
Gene L. Davis, Jr.
Jonathan D. Dehner
V. Rao Devineni
Jacquelyn B. Dilworth
Norman S. Druck
Harry C. Eggleston
Daniel C. Fabito
Kirk E. Flury
Frank H. Gafford
Arthur H. Gale
David L. Gearhart
Richard J. Gimpelson
Stephen E. Godfrey
Daniel H. Goodenberger
Joseph E. Graham
E. Richard Graviss
Manjusha A. Gupte
James M. Hartman
Sam S. Hawatmeh
Michael E. Hayek
George Hruza
William H. Huffaker
Donald R. Ingram
Timothy R. Jones
John G. Kellett
George M. Kichura
Tinna P. King
Jeffrey P. Kirsch
James W. Knight
William A. Knight, Jr.
Russell R. Kraeger
Norton S. Kronemer
John M. Laird
Laurence A. Levine
Herluf G. Lund, Jr.
Kathy C. Maupin
Robert McMahon
Kurt D. Merkel
Jay Meyer
K. Lynne Moritz
Nathaniel H. Murdock
J. Gail Neely
Neal Neuman
Anne-Marie Nicolazzi
John H. Niemeyer
Charles C. Norland
Paul A. Oberle
Robert F. Onder
Henry D. Onken
Tammarah Ostapowicz
Daniel O'Sullivan
Jennifer L. Page
Sam L. Page
Sharad P. Parikh
Frederick D. Peterson
Frank O. Petkovich
David L. Pohl
Samuel G. Ramirez
James C. Redington, Jr.
David M. Reisler
Susan K. Reynolds
Gregory C. Rinehart
Herbert E. Rosenbaum
Jo-Ellyn M. Ryall
Mark A. Scheperle
George R. Schoedinger
Daniel Scodary
Hillard L. Scott
Charles S. Sherwin
Eli R. Shuter
Joseph R. Simpson
Stephen G. Slocum
Kenneth R. Smith, Jr.
Gershon J. Spector
Brent V. Stromberg
Tipu Sultan
Shiraz Sunderji
Manzoor Tariq
J. Regan Thomas
Jeffrey L. Thomasson
Susan C. Threats
Seth Tilzer
Jerry Tobler
Randall W. Tobler
William G. Totty
Roger V. Vardeleon
Garry M. Vickar
Corinne Walentik
Bruce J. Walz
Joseph W. West
Stephen A. Wexler
David L. Wilkinson
Carol F. Williams
J. Michael Zylka
Laura A. Baalmann*
Vernon H. Balster*
Edward L. Burns, Jr.*
Lance D. Gerowin*
Thomas D. Hartnett*
Simon Horenstein*
Ravi S. Johar*
Michael E. McCadden*
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Del Moeller
David Poggemeier
William Sill, DO

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Audrain

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Larry Handlin, DO
Casey Rogers
Glenn Gordon*
Steve Taylor*

Boone

William C. Allen
Mark Bryer
Jennifer Clark
John Cowden
Milamari A. Cunningham
Ted Groshong
Steven Standiford
Stephanie Womack

Cole

Alan L. Braun
Michael A. Young, DO

Lake of the Ozarks

D. L. Cathcart
Carl Petit
George Hubbell
David L. Brown*
Melvin Hayden*

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Johnson

Arthur Freeland

Lafayette-Ray

William LaHue
Charles Riley
John Scowley*
Daljeet Sing*

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William Haynie
Wayne Morton
Richard Price
John Torontow
William A. Turner
Donald Frein*

West Central *(continued)*
Curtis Long*
Warren Lovinger*
Robert Magee*
Glen Reed*

Seventh District

Kansas City
James R. Batterson, Jr.
Steven E. Buie
Richard E. Butin
William B. Daniels, DO
James A. D'Angelo, DO
Robert T. Gibbons, Jr.
Richard Hellman
Rebecca S. Hierholzer
Deborah A. Jantsch
Loretta S. Loftus
Vickie L. Massey
Donald E. McIntosh
Denise K. Miller
Carl M. Myers
Ann M. Romaker
Howard G. Rosenthal
Larry A. Rues
Camilla R. Saberhagen
Carl D. Siegel
G. Donald Stillie, DO
Carl F. Strauss
Russell S. Yocum, DO

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Allan Allphin
Darrel Domann
Jim Blaine
Michael S. Clarke
J. David Gipson
J. Leon Gregston
Charles H'Doubler
Peter Molberg
F. David Muegge
William Reynolds
James T. Rogers
R. C. Scanlon, DO
Catherine Schane
Joni Scott
William Taylor
Mark Tendai
James Wolfe
Andy Wright
Robert Zahn
Karel deLeeuw*
Hal Lurie*

Jasper-Newton
Mark Matlock
I. Joe Pryor
Vijay Rao
James Riscoe
Howard Roberts
Ramesh Shah
Duane Sherrod

Webster
T. M. Macdonnell

Ninth District

Mid-Missouri
Hugh Bartlett

Tenth District

Mineral Area
J. David Auner

Cape Girardeau
Jean A. Chapman
J. Thomas Critchlow
Mel Kasten
Rickey Lents
Richard A. Martin

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Kyle Griffin
Rob King
Scott Schultz*
Geetha Subramanian*

UMKC
Sona Partap
Caroline Cheng*

St. Louis University
Mike Twyman
Kim Schmidt
Robert Kraichely*

Washington University
Roberto Miki
Clint Walker
Lara Rymarquis*
Tessa Madden*

University of Health Sciences
Eric Matlock
Kim Nestor*

IMG

Nicola Katf*

Delegate-At-Large

Past Presidents
Richard Bradley
A. J. Campbell
R. Allen Chandler
T. J. Cooper
James Cope
Gary Dyer
H. Peter Ekern
Joseph L. Fisher
Walter German
Frederick Hahn
Eugene T. Hansbrough
Melvin Kasten
John Matthews
Andrew McCanse
H. Jerry Murrell
Daniel O'Sullivan
Marvin Singleton
James Stokes
Byron Stuart
Carol Williams
Ronald Youmans

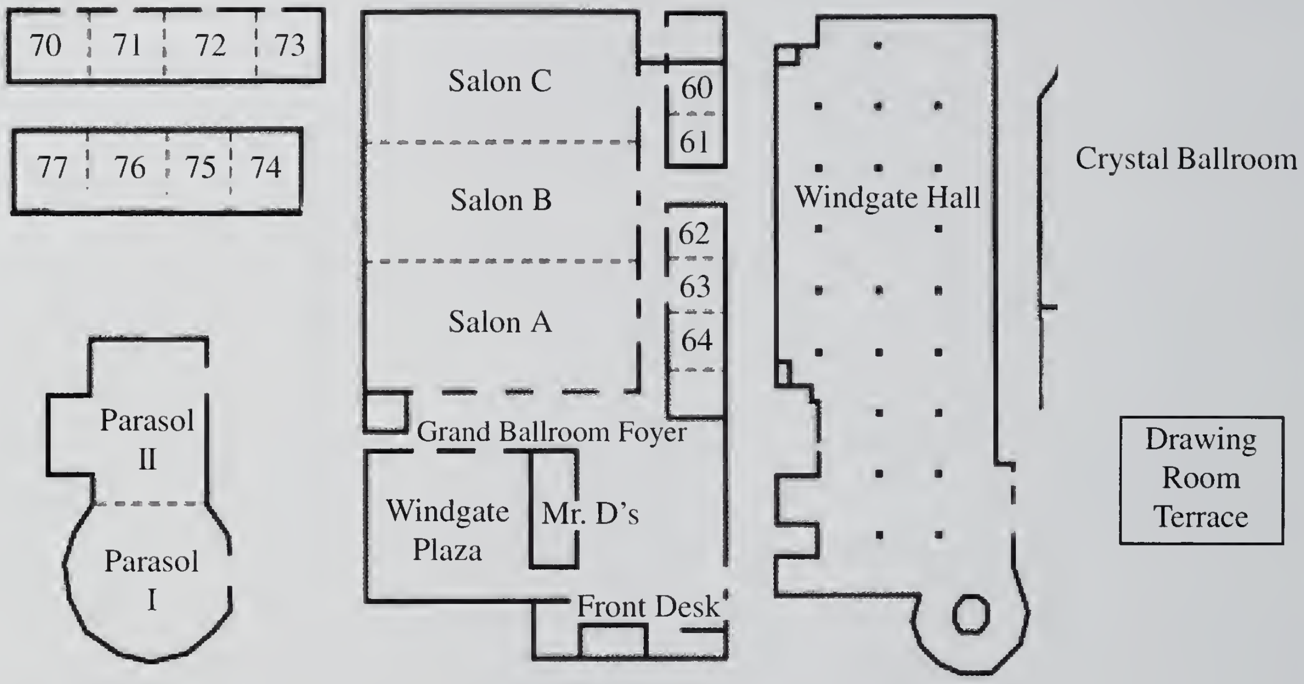
Speaker
John L. Rollo

Vice Speaker
Edwin Masters

Deans
Robert Churchill
Patricia Monteleone
William Peck
Marjorie Sirridge

MSMA 142nd Annual Convention
April 6-9, 2000 Westin Crown Center Kansas City, Missouri

TAN-TAR-A RESORT HOTEL MAP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Parasol II
Parasol I
Salon C
Salon B
Salon A
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64
Grand Ballroom Foyer
Windgate Plaza
Mr. D's
Front Desk
Windgate Hall
Crystal Ballroom
Drawing Room Terrace

Seventh Floor
Sixth Floor
Fifth Floor

Mystery Dinner Theater

Friday, April 9
7:30 pm
$60/person

Missouri State Medical Association
Alliance

Mystery Dinner Theater
Dinner and Silent Auction
Parasol I-II

Proceeds to benefit AMA Foundation

EXHIBIT HALL MAP

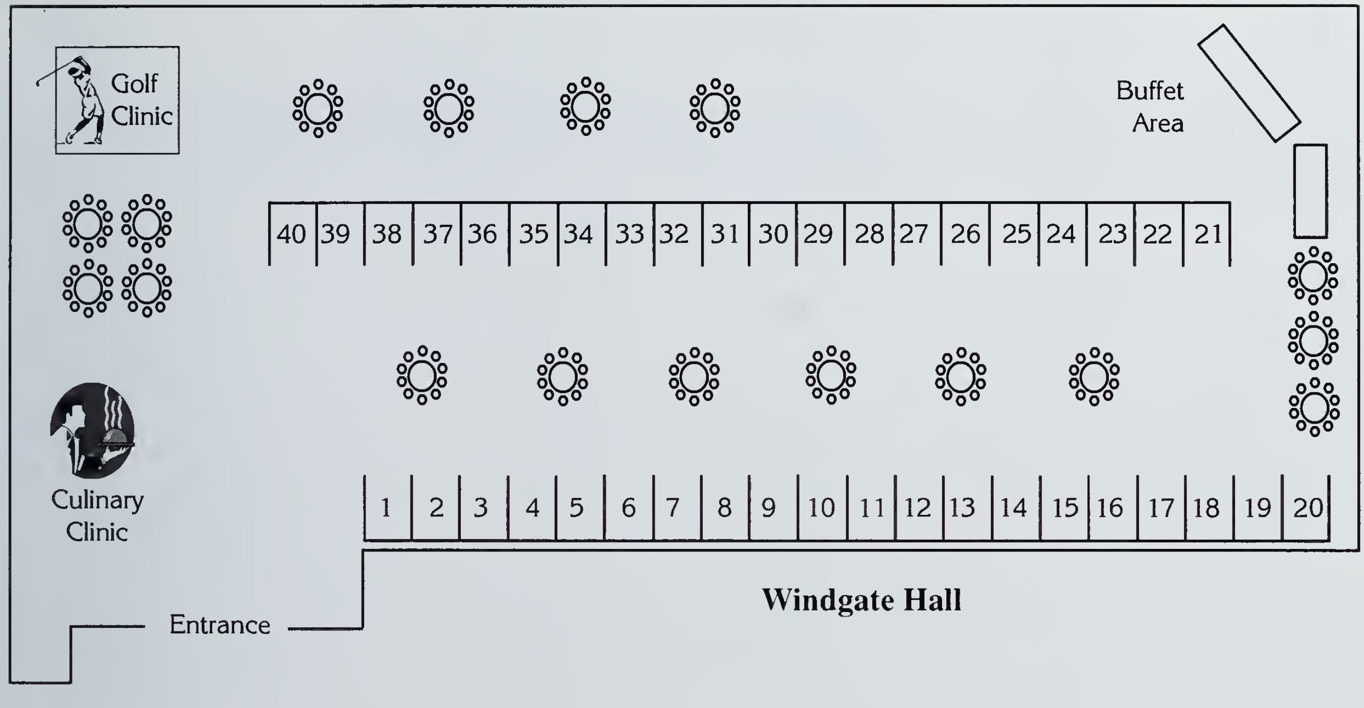
Golf Clinic
Buffet Area
40 39 38 37 36 35 34 33 32 31 30 29 28 27 26 25 24 23 22 21
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Culinary Clinic
Entrance
Windgate Hall

EXHIBIT DRAWING

Winner of Drawings Receives PalmPilot:

The third generation of 3COM small smart connected organizers features infrared, sleek new industrial design. Pocket-size datebook, address book, to-do list, memo pad, expense tracker, email, calculator, games, hot sync upgradeable memory and 2MB. Push button or stylus operation.

1999 MSMA Annual Convention Exhibitor Drawing Guidelines:
Member physicians and medical students must have the form initialed on the line next to the booth number by exhibit personnel at **25 Exhibit Booths**. Fill out your name, address, and telephone number. Form is to be deposited in the drum at the exhibit hall entrance.

Friday Deadline: 4 p.m.
Saturday Deadline: Noon.

Exhibit cards are available at the MSMA Registration Desk.
Winners will be notified - need not be present to win. Winners announced at Sunday's House of Delegates' meeting.

EXHIBITORS

Booth #1

ELI LILLY AND COMPANY

Product Line: Pharmaceuticals
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Indianapolis, IN 46285
Telephone: 800-636-5459 Fax: 800-961-0354

Eli Lilly and Company welcomes the opportunity to support your organization through participation in your exhibit program. We cordially invite you to visit our display and discuss our products.

Booth #2

BAIRD, KURTZ & DOBSON, CPAS
SPRINGFIELD - ST. LOUIS - KANSAS CITY

Springfield Telephone: 417-831-8701
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BKD Services: Strategic planning, managed care consulting, physician integration assistance, third-party reimbursement consulting, compensation plans, contract reviews, compliance services, tax and financing planning, operations reviews, and human resources.

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Medicare Services processes your Part B claims in three-fourths of Missouri.

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THE KEANE INSURANCE GROUP, INC.

Product Line: Professional Liability Insurance
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St. Louis, MO 63127
Telephone: 314-966-7733 Fax: 314-966-7797

The Keane Insurance Group is an agency specializing in providing professional liability insurance and risk management services to health care providers including physicians, surgeons, dentists, managed care organizations, surgery centers, and hospitals. In addition, we offer our clients access to financial planning including estate planning, life, health and disability insurance, pensions, IRAs and investments.

Booth #5

ACUTE CARE, INC.

Product Line: Emergency Medicine Staffing and Management Company
110 Southeast Grant Street
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Telephone: 800-729-7813 Fax: 515-964-2777
Internet: www.acutecare.com

Acute Care, Inc., is a large Midwestern Emergency Physician Group specializing in staffing Emergency Departments in Missouri, Iowa, Nebraska, Illinois, Wisconsin, and Minnesota. Full-time, part-time, and moonlighting opportunities available on several levels. Additional services include Primary Care Locum Tenens coverage, and the development of Oc Med Programs, Emergency Observations Units, and Fast Track Urgent Care.

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Omaha, NE 68111
Telephone: 402-633-5703 Fax: 402-633-1096

Headquartered in Omaha, Nebraska, Physicians Mutual was established in 1902 to serve the health insurance needs of physicians, surgeons, and dentists and was one of the first to pioneer selling insurance by mail. Today, Physicians Mutual and Physicians Life Insurance Company provide a wide range of health and life insurance protection, plus tax-deferred annuities to policyowners nationwide.

Booth #7

AMERICAN MEDICAL POLITICAL ACTION COMMITTEE

1101 Vermont Avenue Northwest
Washington, DC 20005

Booth #8

MISSOURI STATE MEDICAL ASSOCIATION

Product Line: CME, Internet Access, Representation, Consulting, Insurance
113 Madison Street
Jefferson City, MO 65101
Telephone: 573-636-5151 Fax: 573-636-8552
Internet: www.msma.org

Since its founding in 1850, the Missouri State Medical Association has represented Missouri physicians to patients, the public, media, and government. MSMA offers assistance to further the field of medicine through an organized professional membership comprised of more than 6,000 physicians.

Booth #9

DODSON GROUP

Product Line: Workers' Compensation Insurance
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Telephone: 800-825-3760 Fax: 800-825-6035

Workers' Compensation Dividend program for Missouri State Medical Association since 1983.

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Internet: www.navystlouis.com

Preparing physicians for a challenging medical profession with the United States Navy.

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Product Line: Financial Services
700 Corporate Park, Suite 300
St. Louis, MO 63105
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Moneta Group and its affiliated companies comprise the largest independent financial planning organization in Missouri, managing over two billion dollars of assets, coordinating the administration of hundreds of retirement plans, and serving as financial advisor to several thousand individual and corporate clients.

Booth #21
UNITED STATES ARMY HEALTH CARE RECRUITING
500 Northwest Plaza, Suite 802
St. Ann, MO 63074
Telephone: 314-739-3177 Fax: 314-739-5297

Booth #22
HEALTHLINE MANAGEMENT
Product Line: Physician Staffing and Recruiting
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St. Louis, MO 63103-1803
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Internet: www.hmistl.com

Today, and since the beginning in 1985, HealthLine Management has been committed to being the national leader in the health care outsourcing services industry for Emergency Department and Locum Tenens physician staffing services. HealthLine Management also provides important ancillary services to our clientele, including physician recruiting, practice management consultation, credential verification services, and business and strategic planning consultation.

Booth #23
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Product Line: Prepaid Health Insurance
2301 Main Street
Kansas City, MO 64108
Telephone: 816-349-6060 Fax: 816-349-6074
Internet: www.bcbskc.com

Blue Cross and Blue Shield of Kansas City is an integrated health care company servicing Northwest Missouri and the bi-state Kansas City metropolitan area.

Booth #24
PRIME HEALTH MEDICAL GROUP
Product Line: Physician Office Management
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Lenexa, KS 66214
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Management service office for seven primary care, family practice, and urgent care facilities located in the greater Kansas City area.

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QUEST DIAGNOSTICS OF MISSOURI, LLC
Product Line: Full Service Clinical Laboratory
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Quest Diagnostics, a partner with Unity Health, offers a wide range of diagnostic services and medical informatics. Our routine testing services, supported by an extensive infrastructure of patient service centers and information systems, integrates with the specialty testing services of Nichols Institute, Quest's Center for Diagnostic Innovation.

Booth #26
THE MEDICAL PROTECTIVE COMPANY
Product Line: Medical Malpractice Insurance
5814 Reed Road
Fort Wayne, IN 46835
Telephone: 219-485-9622 Fax: 219-486-0807

Professional liability insurance.

Booth #27
MISSOURI PATIENT CARE REVIEW FOUNDATION
Product Line: Missouri Peer Review Organization
505 Hobbs Road, Suite 100
Jefferson City, MO 65109
Telephone: 800-735-6776 Fax: 573-893-5827

Medicare-designated peer review organization for Missouri.

Booth #28
UNITED STATES AIR FORCE RESERVE
Health Professions Recruiting
HQ AFRC/RSOH
115 Second Street
Robins AFB, GA 31098-1635
Telephone: 912-327-0156 Fax: 912-327-0153
Internet: www.afreserve.com

Please visit our booth and get information and literature on the many career opportunities with the Air Force Reserve as a health professional.

Booth #29
SCHERING CORPORATION
Product Line: Allergy/Asthma Products
Galloping Hill Road
Kenilworth, NJ 07033
Telephone: 417-881-3920 Fax: 417-882-0225

Schering is the leader in the allergy/asthma field. Claritin is the #1 antihistamine in the world.

Booth #30
GTE DATA SERVICES
905 Weathered Rock Road
Jefferson City, MO 65101
Telephone: 573-635-2434 Fax: 573-635-0204

Fiscal agent for the Department of Social Services, Division of Medical Services - Missouri Medicaid.

Booth #31

ABBOTT LABORATORIES

Product Line: Pharmaceuticals
200 Abbott Park Road AP30/4D304
Abbott Park, IL 60064-3537
Telephone: 800-255-5162 Fax: 847-938-3237
Internet: www.abbott.com

You are invited to visit the Abbott Laboratories exhibit where representatives will be on hand to answer your questions regarding TRICOR (fenofibrate capsules), micronized.

Booth #32

MEDICAL DEFENSE ASSOCIATES

Product Line: Medical Malpractice Liability Insurance
PO Box 3817
Springfield, MO 65808-3817
Telephone: 417-887-3120 Fax: 417-887-0300

Booth #33

ASTRA PHARMACEUTICALS

12980 Metcalf, Suite 500
Overland Park, KS 66213
Telephone: 913-685-6200 Fax: 913-685-6216

Booth #34

SOUTHERN MEDICAL ASSOCIATION

Product Line: CME, Insurance, Group Purchasing
35 Lakeshore Drive
Birmingham, AL 35209
Telephone: 800-423-4992 Fax: 205-945-1830
Internet: www.sma.org

SMA provides various CME through on-site activities, Internet, SMJ, Dial Access, Video, and Audio access, as well as other resources including insurance, retirement, group purchasing, and travel.

Booth #35

INTERMED INSURANCE CO.

Product Line: Medical Professional Liability Insurance
1903 E. Battlefield
Springfield, MO 65804
Telephone: 417-889-1010 Fax: 417-889-1099

Intermed Insurance Company has been providing medical professional liability insurance to Missouri physicians since 1976. Offering both claims made and occurrence policy forms, Intermed can tailor a policy to meet the specific financial and risk needs of the solo practitioner or group practice.

Booth #36

HEALTH MIDWEST

2316 East Meyer Boulevard
Kansas City, MO 64132
Telephone: 816-276-4263 Fax: 816-276-4020

Booth #37

PHARMACIA & UPJOHN

Product Line: Pharmaceuticals
2001 Butterfield Road, Suite 600
Downers Grove, IL 60515
Telephone: 630-663-9300 Fax: 630-663-9314

Booth #38

FORREST T. JONES & COMPANY, INC.

Product Line: Insurance - Life and Health
3130 Broadway
Kansas City, MO 64111
Telephone: 816-756-1060 Fax: 816-968-0580

Booth #39

MEDICAL EMPLOYMENT DIRECTORY, INC.
ST. LOUIS - KANSAS CITY - SPRINGFIELD

Product Line: Staffing of Permanent/Temporary Medical Personnel
4520 Madison, Suite 205
Kansas City, MO 64111
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Internet: www.med-search.com

Medical Employment Directory, Inc. provides permanent and temporary placement of health care professionals in physician offices, clinics, and hospitals. Our firm recruits physicians for all medical specialties. Medical Employment Directory, Inc., is the leading health care recruiting firm in the Midwest.

Booth #40

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Product Line: Medical Professional Liability Insurance
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MOMEDICO provides professional liability insurance for physicians and dentists as well as other health care providers. Coverage for hospitals, managed care organizations, and other entities is also available. Our reputation is based on a strong defense philosophy and commitment to our insureds.

SPEAKER FACULTY

Susan K. Ailor, MD
President
Missouri Dermatological Society
Columbia, Missouri

Edmond Cabbabe, MD
Associate Professor
Division of Plastic Surgery
St. Louis University School of Medicine
St. Louis, Missouri

Richard Chole, MD, PhD
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MSMA ALLIANCE PROGRAM

Thursday, April 8

4:00-6:00 pm	MSMAA Registration, *Grand Ballroom Foyer*
7:00 pm	MSMAA Dutch Treat Dinner, *J. B. Hooks*

Friday, April 9

7:30-8:30 am	MSMAA Continental Breakfast, *Windgate Hall*
7:30 Noon	MSMAA Registration, *Salon C*
8:30-11:30 am	MSMAA General Assembly, *Salon C*
Noon-2:00 pm	MSMA/MSMAA General Session and Luncheon, *Salon A* (see page 10)
7:30-11:00 pm	AMA Foundation Fundraiser, *Parasol I-II*

Saturday, April 10

7:00 am	MSMAA Past Presidents Breakfast, *Parasol I*
8:00-10:00 am	MSMAA Registration, *Salon C*
8:30-Noon	MSMAA General Assembly Second Session, *Salon C*
Noon	MSMAA Installation-Award Luncheon, *Parasol I*
1:00-4:00 pm	Missouri Chapter, American College of Pediatrics Scientific Program, *Room 63*
3:00 pm	MSMAA Joint Convention Board Meeting, *Parasol II*

Domestic Violence:

Recognition, Intervention and Documentation

Friday, April 9 • Noon - 2:00 p.m.
Salon A

Presented by: Zita Surprenant, MD, Lenexa, Kansas
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Radiology Quiz

Roger A. Francis, MD, FACR
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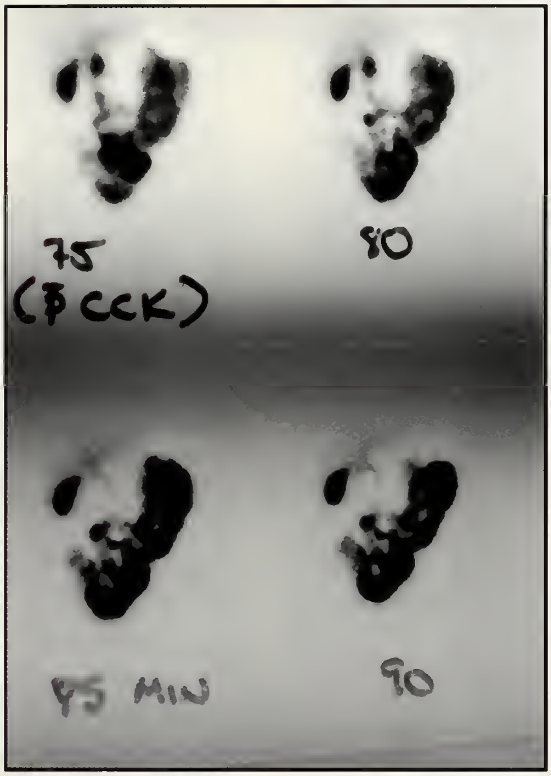

Figure 1

A 27-year-old female presented to the clinic with right upper quadrant pain for one week. A gallbladder ultrasound study (not shown) showed no gallstones. As part of the workup, a hepatobiliary scintigraphic study was performed with images submitted during and after the intravenous injection of 1.4 micrograms of cholecystokinin (Figure 1).

1. **What is the most likely diagnosis**

    a. Common duct stone
    b. Acute cholecystitis
    c. Chronic cholecystitis
    d. Acute pancreatitis

(See answers on next page.)

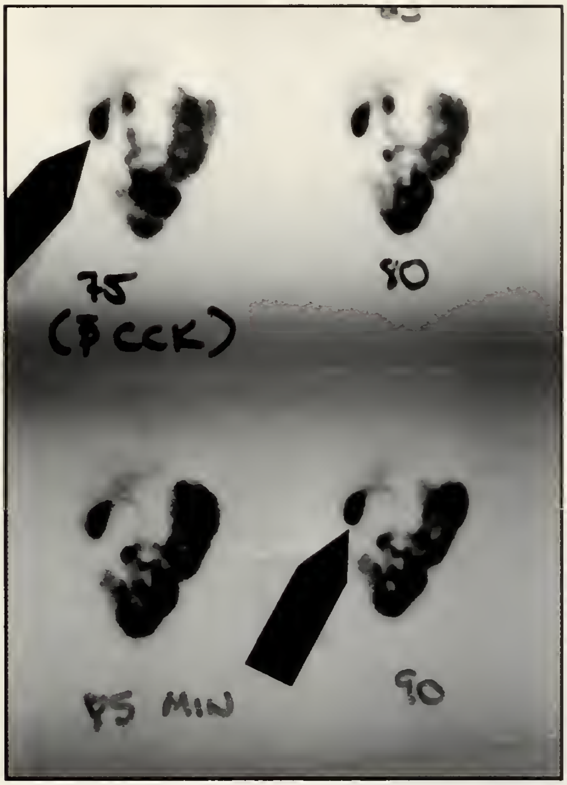

Figure 1 repeated

ANSWER
c - Chronic cholecystitis

Images from a radioisotope hepatobiliary scan (Figure 1 repeated) following injection of 5 mCi. of 99mmTc-HIDA show uptake in the gallbladder (first arrow) and small bowel consistent with patency of cystic duct and common bile duct. Following cholecystikinin injection, additional images show only minimal contraction of the gallbladder (second arrow). Calculated gallbladder ejection fraction is 10%, with normal being 35% or greater. Diminished gallbladder contractility with patency of the cystic duct and in the absence of gallstones would be most suggestive of acalculous gallbladder disease such as chronic acalculous cholecystitis, cholesterolosis or cystic duct dyskinesia. Of the listed choices, chronic cholecystitis is the most likely possibility. Due to continued symptoms, cholecystectomy was performed, and histologic examination of the gallbladder showed chronic cholecystitis.

Common duct stone is unlikely since normal uptake is seen within the small bowel indicating common duct patency.

Acute cholecystitis is unlikely since there is normal uptake seen within the gallbladder consistent with patency of the cystic duct.

Acute pancreatitis would not be expected to cause abnormalities on hepatobiliary imaging, unless pancreatitis is caused by common duct stone.

Radioisotope hepatobiliary imaging has been most often used as an adjunct to ultrasound imaging to look for patency of cystic duct or common duct. In patients with right upper quadrant pain and gallstones on ultrasound, non-visualization of the gallbladder on hepatobiliary scan usually indicates cystic duct obstruction and acute cholecystitis. Another use of hepatobiliary (HIDA) imaging is quantitative hepatobiliary scintigraphy for evaluation of chronic acalculous biliary disorders. In the patient with strong clinical suspicion of gallbladder disease but without stones seen on ultrasound, HIDA scanning may help by confirming cystic duct patency, making acute cholecystitis unlikely. If the gallbladder visualizes adequately with HIDA scanning, gallbladder contractility may be evaluated by intravenous injection of sincalide, an analog of cholecystokinin which results in gallbladder contraction and emptying. Drawing an area of interest around the gallbladder before and after CCK allows calculation of a gallbladder ejection fraction. An ejection fraction of 50% or greater is considered normal, and an ejection fraction of less than 35% is considered abnormal. Impaired contractility is most often seen in acalculous gallbladder disease such as chronic acalculous cholecystitis, cholesterolosis or cystic duct syndrome. **MoMed**

Reference:

- Palmer E, Scott J, Strauss W. *Practical Nuclear Medicine*, Saunders 1992, p. 453-463.

Internet Addiction: A New Type of Addiction?

Thomas Eppright, MD; Maureen Allwood, MS; Barry Stern, MA; Tom Theiss, BS

Abstract

The popular press has discussed Internet addiction as an emerging disorder affecting thousands of people. However, little research has been done in this area. With the media reporting growing numbers of divorce, child neglect and loss of jobs associated with compulsive use of the Internet, professionals and lay persons alike are asking, "Does Internet addiction exist?" The authors review what has been studied to date and make suggestions as to how future research could be beneficial.

Object Dependency

Addictive behavior or dependence as it is called in the literature is generally distinguished from non-addictive behavior by the existence of three factors; compulsion, tolerance, and withdrawal.[1] Compulsion refers to the repetitive behavior pattern, which occurs in relation to the object; tolerance refers to the need for increased quantities of the object in order to achieve satisfaction; withdrawal refers to a maladaptive behavioral or physiological response in the absence of the object.

Addictive behaviors frequently lead to neglect of family members and friends, neglect of responsibilities (e.g. school, work, household), and neglect of self. For some families addiction may mean the erosion of the entire family system, and even financial devastation. There are various theories and conceptual models as to why and how people become addicted. However, most of the literature refers to chemical addictions.[2]

It has long been established that symptoms of compulsion, tolerance, and withdrawal need not be associated with use of a chemical, such as alcohol or cocaine. Psychological dependence on an object has been found to produce the same symptoms without chemical dependency.

Internet Addiction

While the addiction literature is extensive, addictions not related to chemical dependency have not received much attention. For instance, in reviewing psychiatric and psychological journals, there have been few research articles published regarding Internet addiction.[3,4] However, the media and the popular press have published several articles related to the subject.[5,6,7] While media attention to a so-called mental health topic does not constitute the addition or expansion of a diagnosis, it is important that the professional community be equipped to provide valid responses to media and societal inquiries.

Amidst the growing number of media reports of people who lose spouses and/or jobs due to overuse of the Internet, there remains much criticism and cynicism about the concept of Internet addiction. After all, who is harmed by overuse of the Internet? How is Internet addiction different from endless hours of television watching?

Among mental health professionals much of the criticism about the concept of Internet addiction revolves around the lack of empirically based investigation and well-designed research. Most studies conducted regarding Internet addiction have taken place on-line and likewise, the published findings can be found on-line.[3,4] The validity of such research methods have been questioned.[8] There remain many unanswered questions about Internet addiction, with the core question being — does Internet addiction exist? Can use of the Internet be associated with compulsion, tolerance and withdrawal symptoms? This article will review the existing literature regarding Internet addiction; with the caveat that use of the terminology presented in the literature, (e.g. Internet addiction and Internet addiction disorder) is in reference to the conceptualization and should not infer validation of the construct.

Conceptualization of Internet Addiction

Reportedly, the term Internet addiction was first used by Ivan Goldberg, as a joke posted on an electronic message board for professionals.[9] The joke triggered numerous responses from people seeking assistance in overcoming their overuse of the

Internet. Currently, Internet addiction can be defined simply as a psychological dependence on the Internet.[10] However, conceptualization of the etiology of Internet addiction varies. Some suggests that the uncertainty of a "hit rate" in Internet searching have a reinforcing and addictive effect similar to playing slot machines. Others suggest that the Internet provides a safe environment for interaction and self-expression for those who are socially awkward, anxious, physically unattractive, and/or fearful of interpersonal rejection.[11]

To screen for Internet dependency the Center for Online Addiction, www.netaddiction.com, which was developed by Young[12] uses an eight item screening questionnaire adapted from the diagnostic criteria for pathological gambling.

1. *Do you feel pre-occupied with the Internet (think about previous on-line activity or anticipate next on-line session)?*
2. *Do you feel the need to use the Internet with increasing amounts of time in order to achieve satisfaction?*
3. *Have you repeatedly made unsuccessful efforts to control, cut back, or stop Internet use?*
4. *Do you feel restless moody, depressed, or irritable when attempting to cut down or stop Internet use?*
5. *Do you stay on-line longer than originally intended?*
6. *Have you jeopardized or risked the loss of a significant relationship, job, educational or career opportunity because of the Internet?*
7. *Have you lied to family members, therapist, or others to conceal the extent of involvement with the Internet?*
8. *Do you use the Internet as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)?*

Those who answer "yes" to five or more of the items above are encouraged to move to a 20 item "Internet addiction test." Following the test responses, Internet users may enter the "Virtual Clinic" and receive treatment via e-mail or chat room.[12]

Prevalence

While no one knows the true prevalence of Internet addiction the literature offers some guidance; however, little of what is offered is based on scientific findings. In 1995, Goldberg speculated that 150,000 people were already addicted to the Internet and he further speculated that the numbers were growing exponentially.[13] In 1996, Sherer conducted a study by mailing surveys to students. She found that 9% of the respondents experienced symptoms related to Internet addiction.[8] These findings are similar to findings related to other addictive behaviors.

Based on prevalence studies of other addictive behaviors, such as alcoholism, Young estimates that 5-10% of all on-line users may suffer from Internet Addiction Disorder (IAD). This is further estimated to mean two to five million people.[14,15] Young's own estimate serves as an indicator for the problems of on-line Internet research. In her study of 496 people, Young's screening measure indicated that 396 might suffer from Internet addiction, this would suggest a prevalence rate of 80% if participants were drawn from a completely randomized sample.

Who is Most Affected

Some may think of the "Internet addict" as someone in a highly technical field who spends countless hours searching the Internet for technological thrill — a "computer nerd." Preliminary research findings suggest that this is not the case. Although conclusive findings are not available, a review of the literature suggests that those without employment obligations may be the most vulnerable to IAD.[16] In Young's study of 396 "dependents," 42% were retired, disabled, homemakers or students and 39% were non-technical, white-collar employees. Simply put, having free time and accessibility to the Internet may be the most common thread for those addicted to the Internet.[14]

This again raises the question — does Internet addiction exist? Is it maladaptive for those with free time to spend it on the Internet? To date, crime statistics have yet to show an upsurge in shoplifting, assaults, child abandonment, etc., as a result of people craving Internet access. While Internet addiction does not mirror all of the behavioral patterns of chemical addiction it is still reported to wreak havoc on the lives of those affected. Young's sample of 396 potential "netaholics" logged an average of 38 cyberspace hours per week, where the average Internet user reportedly logged on for about 8 hours per week.[17] College students and homemakers are among those who are most likely to overuse the Internet and experience maladaptive effects.

College Students

Developmentally, college students may be particularly vulnerable to the seduction of the Internet. Many college students are given free unlimited access to materials on the Internet at a time when they are facing numerous developmental challenges; transitioning from their parents' home to campuses, changing friendships and romantic relationships, adjusting to increased academic demands. The Chronicle for Higher Education has published a number of articles on Internet addiction; however, most of the articles repeat the same research findings.[8,10,18] Poor school performance and doubling dropout rates have been associated with high Internet use.[10] Likewise, a higher dropout rate among students with high academic abilities has been linked to excessive late-night Internet use.[14] DeLoughry described one student who spent 8 to 10 hours daily on the Internet. Such students have been referred to as "vampires" because of their late hours in campus computer labs.[18]

In response to these excesses, some schools have offered education and support for Internet use to their students. The University of Maryland, began a support group[18] and a computer addiction clinic was established at McLean Hospital which is affiliated with Harvard University.[6,8]

Homemakers

Women who do not work outside of the home may be another group susceptible to Internet addiction. Several newspaper articles have chronicled the lives of women who lost control of their on-line activities.[5,19] Rushkoff speculates that at-home mothers who long for adult contact may use the Internet as a means of gaining such contact.[19] Recently, Internet addiction has been named in a number of divorce cases,[4,5,14] in some of these cases the mothers lost custody of their children due to allegations of child neglect due to their on-line activities. Young attributes some of the increase in on-line activities and decrease in real-life activities to "cyberaffairs," in which a spouse may engage in on-line "romantic and sexual relationships."[14]

Common Online Behaviors

Why are people choosing "virtual lives" in place of real lives? Again, due to scant research in the area of Internet addiction, it is necessary to rely on speculations and limited clinical reports for preliminary answers to this question. The information available suggests that like other addictions, "netaholics" are seeking pleasure and/or escape.[17] According to Young, stepping into a chat room is similar to stepping into a bar and meeting with familiar friends who eagerly await your presence.[7] The chat room patron is able to take on any identity. She/he can choose a name, age, appearance and other identifying information.[14] She/he is also able to interact with others who have common interests and who are equally invested in forming online relationships. Furthermore, these relationships come with the ultimate safety net; anonymity. In reference to chat rooms, the Internet has been called the "modern day equivalent of a masked ball."[13]

While overuse of chat rooms was found to be the most prevalent medium among netaholics, compulsive use of newsgroups, e-mail, and interactive games have also been associated with Internet addiction.[16] Interactive games, such as Multi-User Dungeons (MUDS) in which users type messages to each other while in fictional environments are especially problematic on college campuses.[18]

Associated Disorders

In the ongoing debate regarding the existence of Internet addiction some have asserted that excessive Internet use may be a symptom of other mental health disorders but is not a disorder in and of itself.[18] Established disorders, such as depression and other dependency disorders have been implicated as the core disorders. Young and Rodgers found that those respondents who met criteria for Internet addiction yielded a mean score of 11.2 on the Beck Depression Inventory. These findings were interpreted as being illustrative of a high incidence of depression among netaholics.[20] Further research is needed in this area to delineate symptom from syndrome.

The Need for Research

Similar to decades-old discussions regarding compulsive gambling, Internet addiction has its skeptics. Some, such as Leo[21] go so far as to insinuate that psychiatrists and psychologists derived the concept of Internet addiction as a way to broaden what is defined as a disorder, thereby increasing clientele. Well designed studies would help to answer the questions; is Internet use associated with compulsion, tolerance, and withdrawal, and if so, what are the risk factors? Research, such as screening college students through selected courses and through the college e-mail system would provide insight into normative versus pathological use of the Internet and would facilitate in the identification, and treatment of those individuals whose Internet usage has become problematic. Additionally, research efforts, such as gathering case reports and surveying log-on records of professional and non-professional use of the Internet, would be able to provide valuable information and influence intervention strategies.

Should college students be given unlimited Internet time? Should employers who provide unlimited Internet time to employees, also provide Employee Assistant Program services for the identification and treatment of Internet addiction? Should web servers share in the responsibility of regulating Internet time? The list of questions scroll on and of course at the head of the list is the ultimate question; does Internet addiction exist?

In conclusion, it is imperative that screenings for maladaptive Internet use begin to take place in the classrooms, within households, as well as in the business sector. Without further insight the potential consequences of promoting avid Internet use among primary, secondary and higher education students remain unknown. While advocating the use of such technology has tremendous benefits, perhaps there should be safeguards in place to enhance real life social outlets while decreasing the seduction of virtual lives. MoMed

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Members In The News

Richard B. Jennett, MD, Jefferson City, was elected Jefferson City Medical Group (JCMG) President by shareholders at a recent meeting. He succeeds **Donald P. Miller, MD,** who served as JCMG President from 1995-1999. Other officers of the group are **Michael Craighead, MD,** Vice President and **Timothy McIntire, MD, MBA,** Medical Director.

Investigators at Washington University School of Medicine in St. Louis have found that a mechanism key to immune-privilege in the eye also plays a role in age-related macular degeneration, the leading cause of blindness in people over the age of 60. **Henry J. Kaplan, MD,** professor of opththalmology and visual sciences, was an investigator in this research.

David M. Ota, MD, FACS, Columbia, was recently appointed Missouri State Chair of the American College of Surgeon's Cancer Liaison Program.

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

Jo J. Callaway, *Kansas City*
John B. Crane, *Washington*
Robert K. Dorton, *St. Louis*
Mark J. Hoffman, *St. Louis*
Lyell M. Magruder, *Nevada*
Jay L. Meyer, *St. Louis*
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In Memoriam

Victor L. Paletta, MD, 54, St. Louis, died February 3, 1999. Dr. Paletta was a cardiologist and a member of the Missouri State Medical Association.

Joseph W. West, MD, 77, St. Louis, died February 11, 1999. Dr. West was an otolaryngologist and a member of the Missouri State Medical Association.

Warren A. Bowersox, MD, 80, Pacific, died February 19, 1999. Dr. Bowersox was a general surgeon and a member of the Missouri State Medical Association.

Francis X. Lieb, MD, 74, St. Louis, died February 19, 1999. Dr. Lieb practiced pediatrics and was a member of the Missouri State Medical Association.

Harold M. Cutler, MD, 90, St. Louis, died February 22, 1999. Dr. Cutler was an otolaryngologist and a member of the Missouri State Medical Association.

Lawrence E. Giffen, DO, 76, Jefferson City, died March 1, 1999. Dr. Giffen was a family practitioner and a member of the Missouri State Medical Association.

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Univ of MO-Kansas City 1991

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Washington, MO 63090
Washington Univ 1981

CME Listing

April

8 & 9 - *St. Louis:* 31st Annual Matt Weis Symposium. Call St. John's Mercy Medical Center 314-569-6290.

10 - *St. Louis:* New Approaches to Common Gastrointestinal Disorders. 4.5 credit hours. Call St. Louis University CME office 314-577-8167.

12 - *St. Louis:* Leroy Sante Lecture. Call Mallinckrodt 314-362-7130.

14 - *St. Louis:* Asthma Physician Preceptorship Program. 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

16 - *Kansas City*: 5th Annual Symposium for and about Women Physicians. 6 credit hours. Call Kim McChesney 816-932-5140.

16 thru 18 - *St. Louis:* ATLS Call St. Louis University 800-553-2712.

16 thru 18 - *St. Louis:* Mental Health & Aging. St. Louis University 800-553-2712.

16 thru 18 - *St. Louis:* Sexuality and Aging. 13.75 credit hours. Call St. Louis University 800-553-2712 or 314-577-8167.

17 - *St. Louis:* Sinusitis: Into the New Millennium. 7 credit hours. Call St. Louis University 800-553-2712.

19 thru 23 - *St. Louis:* Medicolegal Death Investigator. Call St. Louis University 800-553-2712.

22 thru 24 - *St. Louis:* Surgical Approaches to the Skull Base. 22 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

23 & 24 - *St. Louis:* Oncology in the New Millennium. 11.5 credit hours. Call Washington University 314-362-6287.

29 & 30 - *St. Louis:* Couples Therapy in the 90s: Advances and Innovations. Call Judith Brandes 314-569-6290.

May

3 thru July - *St. Louis:* Health Care Ethics in a Pluralistic Society: The Catholic Perspective. Call St. Louis University 314-577-8167.

10 - *St. Louis:* Musculoskeletal Radiology. Call Mallinckrodt 314-362-7130.

25 & 26 - *Springfield:* Pediatric Advanced Life Support. 16 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

June

3 - 5 - *Branson:* Update for Primary Care Physician. 14 credit hours. Call St. Louis University 314-577-8167 or 800-553-2712.

4 & 5 - *St. Louis:* Neurosurgical Endoscopy. 14 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

6 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 6 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

9 - *St. Louis:* Asthma Physician Preceptorship Program. 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

9 thru 11 - *St. Louis:* Summer Geriatrics Institute. Call St. Louis University 800-553-2712.

17 thru 20 - *Lake of the Ozarks:* MAFP 51st Annual Meeting. 18+ possible credit hours. Call 816-941-3939.

July

10 & 11 - *Springfield:* Pediatric Advanced Life Support. 16 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

14 - *St. Louis:* Asthma Physician Preceptorship Program. 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

25 thru 30 - *Kansas City:* The Second Annual Greater Kansas City Internal Medicine Board Review Course. 43 credit hours. Call Kim McChesney 816-932-5140.

26 thru 29 - *St. Louis:* Masters: Advanced Death Investigation. Call St. Louis University 800-553-2712.

August

11 - *St. Louis:* Asthma Physician Preceptorship Program. 8.5 credit hours. Call Washington University 800-325-9862 or 314-362-6891.

20 thru 22 - *St. Louis:* Cervical Spine Decompression and Stabilization. 18 credit hours. Call Sandy Turk, Practical Anatomy Workshop of St. Louis University 314-535-4000.

September

10 - *Springfield:* Pediatric Advanced Life Support provider renewal course. 5.50 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

27 thru 29 - *St. Louis:* Sellar & Parasellar Pituitary Tumors. 15 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

October

1 thru 10 - *St. Louis:* The Pterional Approaches. 32 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

15 - *Springfield:* Advanced Pediatric Advanced Life Support instructor course. Call Maryann Jeter 417-885-5400 or 800-835-5201.

November

12 & 13 - *St. Louis:* Neurosurgical Endoscopy. 14 credit hours. Call Sandy Turk, Practical Anatomy Workshop St. Louis University 314-535-4000.

12 thru 14 - *Branson:* MAFP Fall Conference. 10+ credit hours. Call 816-941-3939.

14 - *St. Louis:* Endoscopic Release of the Carpal Tunnel. 6 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

19 - *Springfield:* Pediatric Advanced Life Support instructor course. Call Maryann Jeter 417-885-5400 or 800-835-5201.

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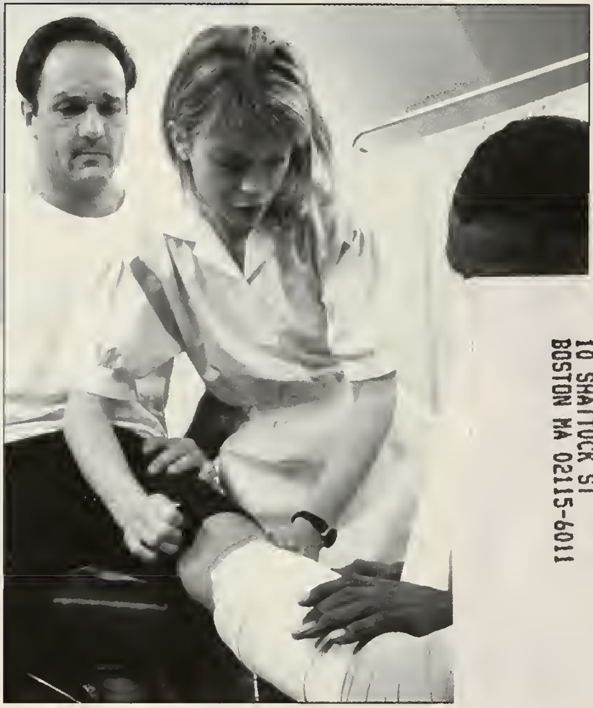

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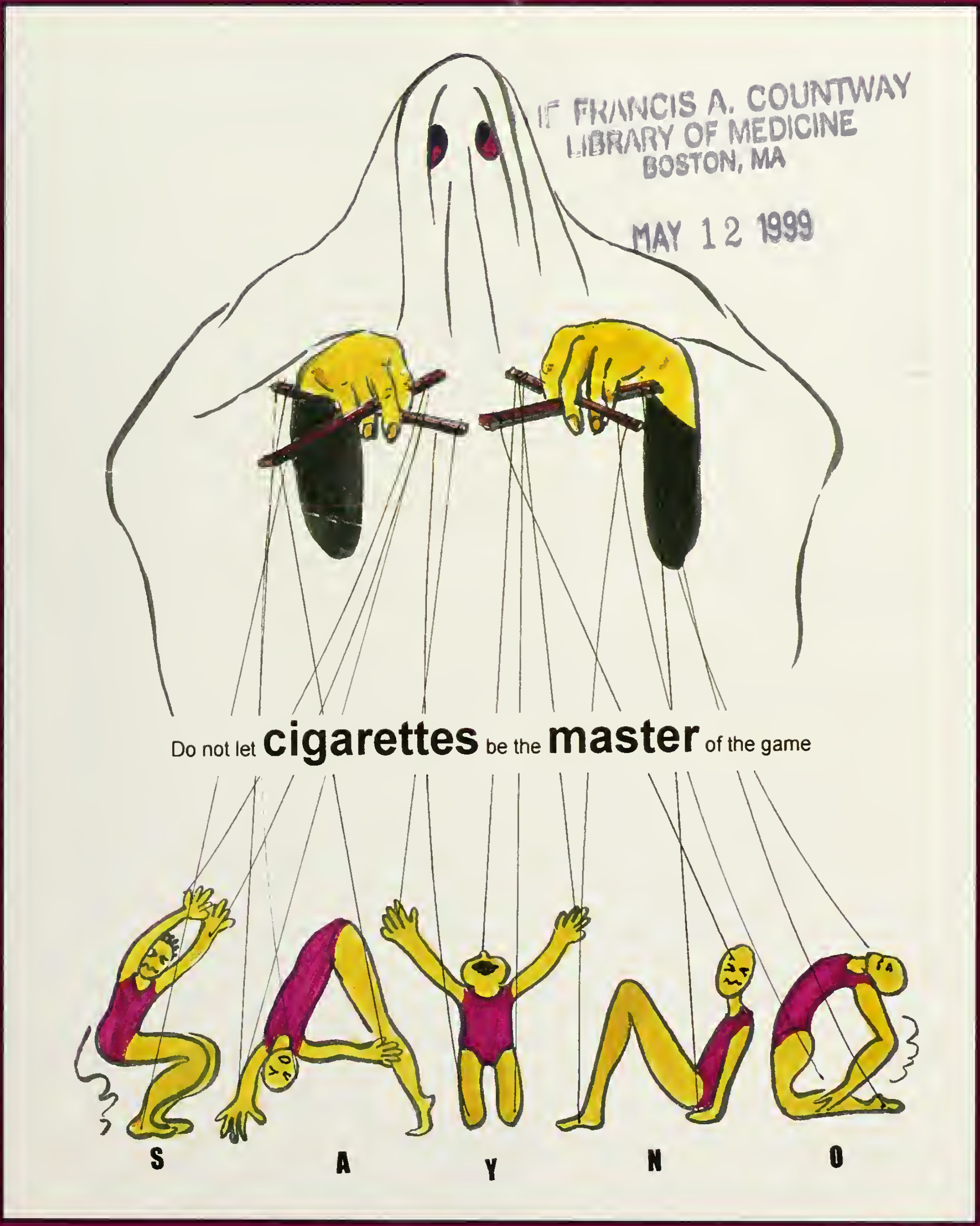
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On the Cover: "Do not let cigarettes be the master of the game" - by Vincent Sung. Vincent is a student at the Warrensburg Middle School. This is the winning entry of the MSMA Resident Physician Section anti-tobacco poster contest. For more information about the contest, see page 154.

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Let's Get The Lead Out

J. Regan Thomas, MD

About a year ago, I wrote an editorial about the dangers that continue for Missouri's children from lead poisoning. Most comes from exposure to lead-based paint in older homes where children eat paint chips or breath in lead contaminated dust. When the article was published, I received a letter which noted that lead-based paint was banned in the late 1970s (actually 1978) and accordingly it was hard to believe that the problem was as significant as I suggested in the editorial. I wish that individual was correct about the severity of the problem, but he was not. There are still many houses and apartments which provide shelter for young children with old paint present. Usually, these are homes of poor families who are the least able to correct the problem. Often they are dealing with landlords who refuse to correct the problem. The families may not go to the authorities for fear of being evicted or losing their home.

Here are some important things to remember about lead exposure in children. Lead can cause a variety of CNS and neurological damage in children in addition to renal problems and other systemic illnesses. Learning disabilities and a predictable negative impact on I.Q. are well documented. Children with high blood lead levels are more likely to have difficulty in school, develop a number of behavior disorders and may exhibit inappropriate aggressive behavior.

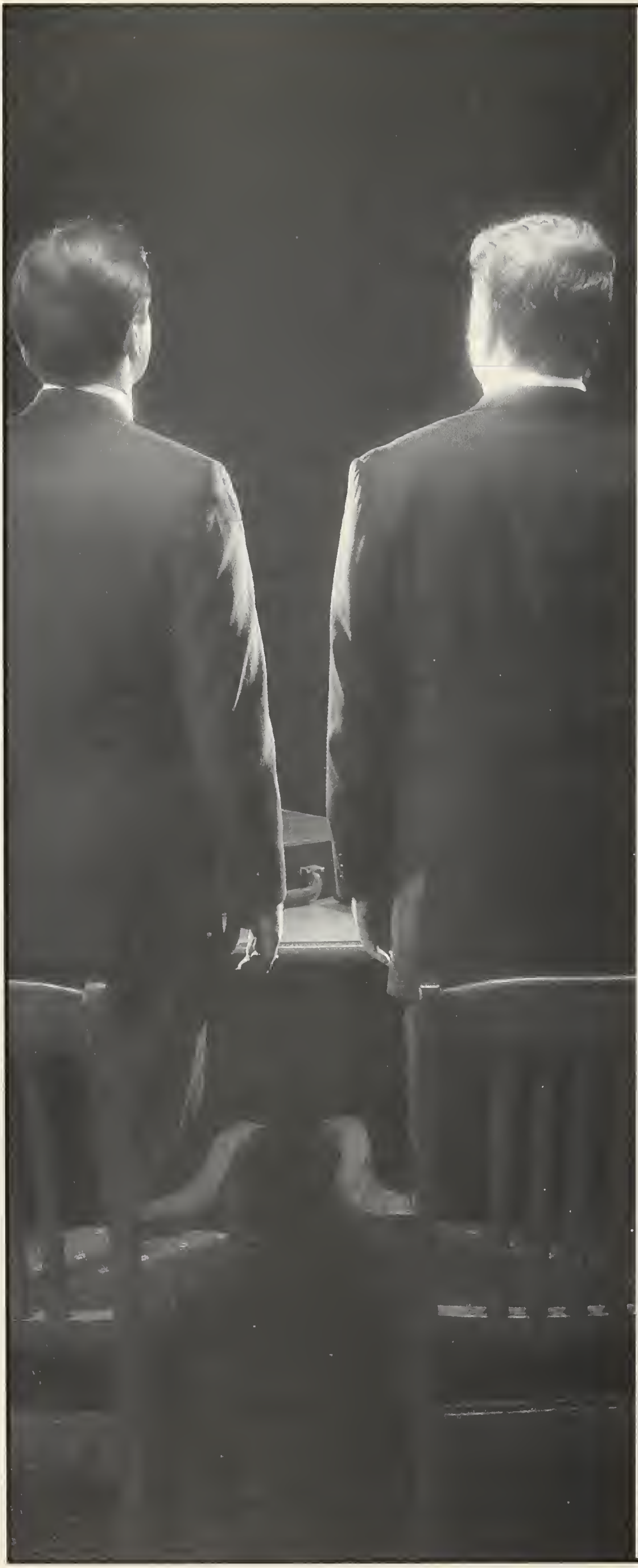
The problem is widespread and significant in terms of numbers. In St. Louis City for example, 25% of the children tested in 1997 had elevated lead levels (five times the national average). In some areas across the state, the number of children affected may reach 40% according to some estimates.

Last year, the state legislature did pass some regulations that allowed for city health inspectors to check for lead contamination on a more active basis. Unfortunately, the legislation was cumbersome in some ways and both slower and less effective than intended. It required, for example, that health officials notify property owners by certified mail before conducting lead inspections. This aspect of the regulation was costly and slow. Now, at the time of this writing, the Missouri House has passed a bill improving the regulations and allowing the health inspectors to notify the property owners by phone. Hopefully, the Senate will also pass the bill and it will go on to the Governor's office for signing.

Even if these steps occur, more needs to be done. Here are some suggestions:

1. More screening of children needs to be done and at low cost to the families, perhaps through the school or day care setting. Currently, only a small percent of the state's children at risk are screened. These children with high levels need to be recognized early before permanent damage occurs.
2. Private pediatricians and other primary care providers must be more aware of the need for screening and participate in the effort. This should include those physicians who contract with Medicaid providing managed care.
3. There should be stronger regulatory oversight to insure that landlords and homeowners make their property lead safe for renters, tenants, and buyers. To facilitate this, there should be incentives and support to help the property owners comply.
4. There should be statewide protections to prohibit landlords from evicting their tenants for allowing their homes and apartments to be inspected for lead paint contamination by health officials.
5. There should be a greater emphasis on public education about the risks of lead exposure to children.

Perhaps the last point is a good first step for us as physicians. We are an important resource for education to our patients and communities about public health issues such as this. The children of Missouri are depending on us to help. MoMed



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Letter to the Editor

Boxing and the Fight to Ban It

To the Editor:

I agree that boxing is a violent "sport" (*MO Med* 1999;96:80) and wonder about the mental status of participants, but would not consider a ban. Boxers are or should be made aware of the imminent dangers to life and limb, then if desired they should be able to accept the risk. What should be mandatory is their and/or the boxing federation held accountable for their health care. They have the right to risk death and disability, but should not become wards of the state. As long as they are responsible for the results of their decisions they should be left alone.

Y.E. Silliman, MD

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Until They Know How Much You Care

Erik Stratman, MD

At the medical school commencement
Clad in tassel, cap, and gown,
I reflected on the lessons learned
Amidst four years of ups and downs.

Which was the most important
Of the pearls which came my way?
Many surrounded me with brilliance.
Carefully, I'd listen to what they'd say.

Study hard, get good grades,
Top tenth on your board scores,
Add a prefix to *cum laude* and
Your match day value soars.

Good advice, most certainly.
Knowledge is a key to curing ills.
But this most important lesson
Did not involve academic skills.

Nor did it come from a textbook,
a professor, or clinician.
It was actually a patient of mine
Who gave this advice for physicians.

It involves offering Kleenex
In a sorrowful situation.
Walking a mile in a patient's shoes
Instead of showing your frustration.

Looking your patients in the eyes,
Using language they'll understand,
Knowing the all-importance of honesty,
Genuine smiles, and holding hands.

It's not easy being a good doctor
And brains certainly play a part.
But to best break through to patients
You must make visible your heart.

So live this simple lesson
Which my patient asked me to share:
Patients don't care how much you know
Until they know how much you care. **MoMed**

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William E. Dorzab, MD
MSMA President

William E. Dorzab, MD

William E. Dorzab, MD, a Pathologist from Raytown, Missouri, will serve as President of the Missouri State Medical Association in 1999-2000. He was formally installed April 10, during MSMA's 1999 Annual Convention in Osage Beach.

Dr. Dorzab earned his medical degree in 1971 from the University of Kansas School of Medicine. His post graduate training included a residency at the University of Kansas in Anatomic and Clinical Pathology, 1971-1975.

Dr. Dorzab has been a member of the Missouri State Medical Association since 1979, when he returned from a two-year post in the United States Army as a pathologist in the 10th Medical Laboratory in Europe. He has served the MSMA as Vice Councilor to the Seventh District, 1987-1990; and as Councilor, 1990-1998. He was Chair of the Council in 1997-98 and Vice Chair in 1996-97. He was a Delegate to the MSMA Hospital Medical Staff Section, 1987-1996, and was Chair of this section from 1989-1995. Dr. Dorzab served as President, Secretary, Director, and Editor of the Bulletin for the Metropolitan Medical Society of Greater Kansas City.

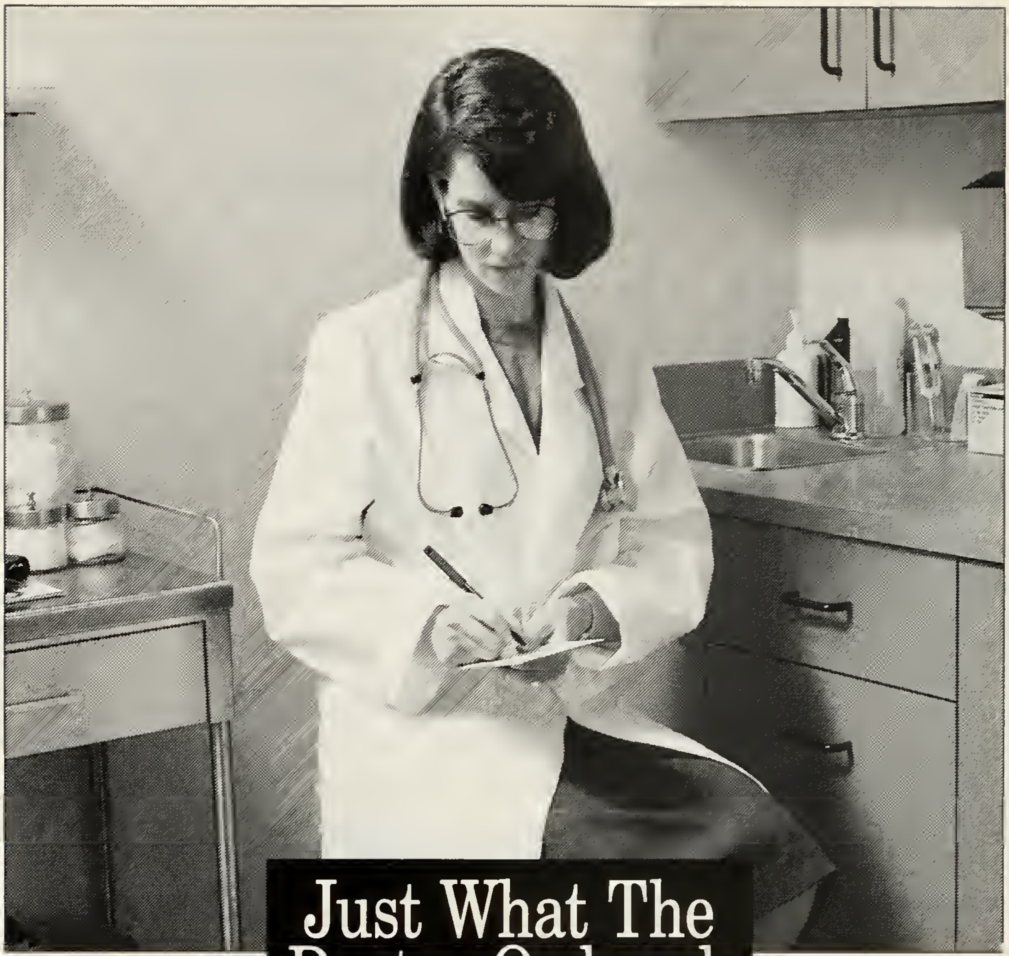
As a member of the American Medical Association, he has served as an Alternate Delegate to the House of Delegates since 1996 and Delegate to the Hospital Medical Staff Section (now Organized Medical Staff Section) since 1983 for Menorah.

Dr. Dorzab is a member and Past President of the Missouri Society of Pathologists, and a Fellow of the College of American Pathologists.

He now practices in Kansas City at the Menorah Medical Center, the Park Lane Medical Center, the Baptist Medical Center, the Trinity Lutheran Hospital, and the Medical Center of Independence. He has served as the President of the Medical Staff and as Chairman of the Medical Staff Department of Pathology and Director of Laboratories at Menorah Medical Center. He has been a Clinical Assistant Professor at the University of Kansas School of Medicine since 1978 and the University of Missouri-Kansas City School of Medicine since 1987.

Dr. Dorazb is married to Linda Dorzab, MD.

In assuming his leadership position for the Association, Dr. Dorzab's goals are to make the Association an indispensable element of every practicing Missouri physician's professional life and a vehicle for delivering practical solutions for the challenges encountered in medical practices. MoMed



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Beverly Murrell
MSMA Alliance President

Beverly Murrell was installed as the 1999-2000 President of the Missouri State Medical Association Alliance April 10, 1999, at the 74th MSMAA Annual Convention at the Tan-Tar-A Resort in Osage Beach.

After graduating from the University of Colorado School of Medicine, Beverly interned and began a residency in pathology at Sacramento County Hospital (now University of California-Davis Hospital). There she met and married Jerry Murrell, an intern from Texas. After Jerry's Navy service, radiology residencies, and practice in the Southwest, they came to Columbia, Missouri, in 1984 where Jerry has practiced radiation oncology since. He is a past president of MSMA. Beverly and Jerry have three children:

- Hugh is a biologist with the Missouri Department of Natural Resources. His wife, Mary Lee, is a journalist with the University of Missouri-Columbia School of Medicine; she edits the *Missouri Medical Review.*
- Heather is a student and works part-time at a veterinary hospital.
- Hudson is finishing the last year of a three-year commitment to the JET Program, teaching English in a high school in Fukono, Japan.

Beverly has been a member of the Boone County Medical Society Alliance since 1984. She served as co-president with Ann Moreton in 1991-92; she was also a county president in New Mexico.

Her other volunteer activities, now that she has outlived child-oriented ones, include the Health Adventure Center Board, P.E.O. Chapter I.T., Calvary Episcopal Church, Museum Associates of the Museum of Art and Archaeology, Mid-Missouri Assistance League and the Columbia Art League.

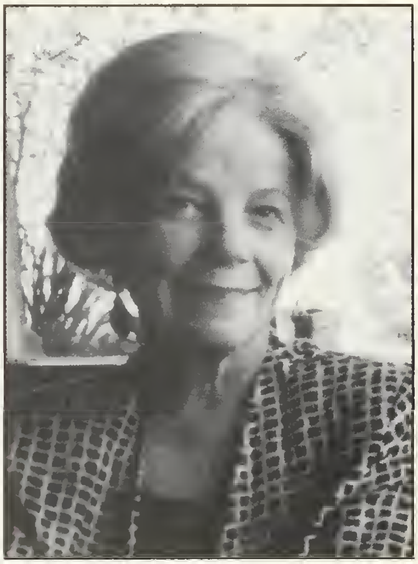
Beverly particularly enjoys studying foreign languages at Mizzou and Stephens College; she then travels to the foreign country to practice the language. She enjoys tennis, aerobics, and playing the piano.

On the MSMAA board, Beverly has held the positions of vice president for AMA-ERF, Health Projects, Legislation, and MMPAC chairman.

"Now is the Time: Make Healthy Choices" is Beverly's theme for the year. "Time is in very short supply," she says. "No one EVER seems to have enough of it. We must use every moment that we have."

She notes the Alliance will continue its ongoing efforts for the AMA Foundation, its interaction with legislators, and its various health projects.

"However," she says, "now is EXACTLY the time to make a VERY important choice by turning our undivided attention to a serious situation: Membership. The number of Missouri members is down to 780. In 1998 the March 31 total was 853; the year-end total on June 30, 1998, was 875. We are behind this year and we need all the members we can get!" The Alliance, she stresses, needs their presence at meetings in the counties – where the action really is – for help with projects. It needs members in numbers to speak for the welfare of the patient with a louder voice. It needs them to join in the medical community's crusade to encourage healthy lifestyles for the larger community as a whole.


Beverly Murrell

Following is a list of some Alliance plans for the year.

- A Leadership Training Conference is scheduled for June 29 at the Country Club of Missouri in Columbia. This conference is particularly important for county officers and chairs who can share ideas that have worked and can learn new ideas from others.
- Fall Conference will be October 27 in Cape Girardeau.
- MSMAA Day at the Legislature is yet to be scheduled; but will more than likely be in late February 2000.
- The 75th Annual Convention will be held April 5-9, 2000, at the Kansas City Westin Crown Center. MoMed

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MSMA's Young Physician Section Elects Officers and Establishes Priorities

Joni Scott, MD
MSMA Young Physician Section Councilor and Chair

The first meeting of the MSMA Young Physicians Section was held in conjunction with the Annual Convention at Tan-Tar-A Resort in Osage Beach. Newly elected officers for this term include, Joni Scott, MD, Councilor and Chair, and Larry Handlin, DO, Vice Councilor. Delegates to the AMA are Sam Page, MD, and Mignon Makos, MD. The delegate to the MSMA is Susan Colbert Threats, MD, and the alternate delegates are Greg Galakatos, MD, and Mary Vest Mason, MD.

Establishing priorities for the upcoming year was the next item of business, and all agreed that increasing membership in the newly created section was at the top of the list. We will increase our profile through *Missouri Medicine,* try to contact members and non-members on a one to one basis to encourage membership, and survey all young physicians to determine activities necessary to increase involvement (please see survey in this issue of *Missouri Medicine*).

The definition of "young physician" for this section is any physician who has completed residency and fellowship training, and is below the age of 41 OR has completed residency or fellowship less than five years ago. If you meet either of these qualifications, this organized group of go-getters is for you. We need your input to be the kind of organization that will allow you to want to be involved.

We are considering solicitation of nominations from the councilor districts for an outstanding young physician's award to recognize community service, or going above and beyond the call of duty. Only members of the MSMA will be considered for this award.

Please complete the attached, postage paid survey for an opportunity to win a $100 gift certificate from Barnes and Noble. A total of three gift certificates will be given away, and names will be announced in *Missouri Medicine.* Winners will also be notified by mail, phone, or email. MoMed

MSMA Young Physician Section

If you are a physician who has completed residency and fellowship training, and is below the age of 41 OR has completed residency or fellowship less than five years ago, please fill out the enclosed survey and become a member of our team. By filling out the survey, you will have the opportunity to win one of three $100 gift certificates from Barnes and Noble. We're looking forward to hearing from you!

Resident Physicians tell students – "No Ifs, Ands, or BUTTS – NO SMOKING!"

Mary V. Mason, MD
AMA-Resident and Fellow Section Governing Council
National Contest Chairman, "No Ifs, Ands, or BUTTS-NO SMOKING!"

Ask any resident physician to think back to those fateful medical school interviews. The question, "Why do you want to be doctor?" The answer invariably included the phrase, "I want to help people."

Unfortunately, the time demands and stresses of residency training leaves little time for house officers to reach out and participate in the betterment of their communities and their patients' lives. It is such a shame; community service adds a vital dimension to the training of physicians. It makes us remember why we wanted to be doctors in the first place.

In order to create a community service opportunity for residents, the American Medical Association's Resident and Fellow Section (AMA-RFS) sponsored a second annual anti-tobacco contest entitled, "No, Ifs, Ands, or BUTTS – NO SMOKING!" The poster contest, open to all 6th-8th graders from across the country, was designed to help combat teenage smoking and thus create a smoke-free America.

Members of the Missouri State Medical Association-Resident Physician Section made several visits to St. Louis area schools in conjunction with the contest. During classroom visits, residents showed students first-hand the damaging effects of smoking on the body through inspection of an actual lung of a smoker who died of lung cancer.

The smoking facts learned in health and science class took on new meaning as students discovered, through use of a peak flow meter, how laborious it would be to breathe with obstructive lung disease.

The smoking facts learned in health and science class took on new meaning as students discovered, through use of a peak flow meter, how laborious it would be to breathe with obstructive lung disease. After such vivid demonstrations, it was easy to encourage the middle school students to be creative and create posters that would help discourage their peers from taking up the addicting habit of smoking tobacco.

The state contest chairman, Jeremy Rower, MD, a second year resident in the Barnes-Jewish Hospital Internal Medicine-Primary Care Program, coordinated the judging of posters from more than 80 Missouri schools. According to Dr. Rower, the state contest was a great success. "The students are forced to think about choices they must make about smoking when designing their poster. The residents are provided an excellent opportunity to not only educate their community, but also make a difference in the health of their patients. With a contest like this, everyone wins."

After the difficult task of judging the posters, Missouri residents chose Vincent Sung's poster, "Do not let cigarettes be the master of the game," as the state winner. Vincent is a student at the Warrensburg Middle School. Bonni R. Rimmer, Westran Middle School, and Bill Woodward, Knox County R-1 Middle School, won second and third place respectively.

The American Medical Association-Resident and Fellow Section is awarding a grand prize of a $500 saving bond to the national winner, and $100 saving bonds to the four national finalists. MoMed

Rule Number 9

Gary A. Dyer, MD

The search for a useful limited set of rules to live by is an ongoing individual quest for physicians and non-physicians. Many would say that the paraphrased golden rule of Saint Matthew,[1] *do unto others as you would have them do unto you*, is all that is needed. For a free society to thrive, almost certainly the Irish proverb [rule], *each man must carry his own sack to the mill*, must apply at least most of the time. Very frequently, in our increasingly corporate society, we hear it stated that the "new golden rule" is *he who has the gold – rules* even to the point of selectively voiding the Rule of Law.

In creating a personal set of rules to live by, Thomas Jefferson's Decalogue of Canons for observation in practical life (now commonly known as Thomas Jefferson's Ten Rules)[2] deserves study:

1. Never put off until tomorrow what you can do today.
2. Never trouble another for what you can do yourself.
3. Never spend money before you have earned it.
4. Never buy what you don't want because it is cheap.
5. Pride costs more than hunger, thirst, and cold.
6. We seldom repent from having eaten too little.
7. Nothing is troublesome that we do willingly.
8. How much pain the evils cost us that never happened.
9. Take things always by the smooth handle.
10. When angry, count to ten before you speak; if very angry, count an hundred.

All of his rules are well put, but I find myself in need of working on Rule Number 9 almost daily.

In the practice of medicine, rules to live by are often difficult to develop and follow. The most famous is, of course, *first, do no harm!* Philip C. Anderson, MD, Professor of Dermatology at the University of Missouri-Columbia, was the unknowing source of the following rules[3] for physicians (each is the distillation of a lengthy discussion with the Chief):

1. Always a Student.
2. Know Everything.
3. Prevent Surprise.
4. Practice with Confidence.
5. Stay in the Mainstream.
6. Share the Heat.
7. Dump Grief.
8. Give Something Back.

Some explanation is in order. *Prevent surprise* means the thorough, thinking, focused physician will nearly always have the final diagnosis in the differential diagnosis. Physicians who *share the heat* seek consultation on difficult cases. Physicians who *dump grief* freely admit that selected specialists or centers can handle certain problems better than they can and refer appropriately. Like scripture, *give something back* can be interpreted in different ways. My interpretation is that each successful medical school graduate should contribute financially to his or her alma mater. Others take the statement to mean that "borrowed" books and slides should be returned. Still others believe he was referring to teaching, charity care, or other contributions to organized medicine and the local community. Although assembled tongue-in-cheek, "Phil's Pearls," properly interpreted, are succinct and solid. If this list were expanded to nine, observation of Dr. Anderson's approach to medicine and life would suggest that he would agree with inclusion of Thomas Jefferson's Rule Number 9. Number ten would require much further study!

My personal list of rules is constantly in a state of reformulation but, beyond the "given" of *stay married to the first spouse*, currently includes:

1. Family and freedom first.
2. Simplify, simplify, simplify.

3. Bloom where planted.
4. Today's work, and perhaps exercise, today.
5. Live within means: create more means.
6. Pay yourself first.
7. Give charity from the heart.
8. Listen twice: speak once.
9. T.J. Rule Number 9.
10. Laugh often with a few good friends.

Rules are simply guideposts to help individuals resist the pressures to stray from a personally chosen better pathway of life. The list that will give the most meaning and potential for happiness must be quite individually and thoughtfully tailored. All lists, however, would do well to include Thomas Jefferson's Rule Number 9: *take things always by the smooth handle.* **MoMed**

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2. Jefferson TJ. Letter to Thomas Jefferson Smith. *The Writings of Thomas Jefferson*. Lipscomb AA Ed. The Thomas Jefferson Memorial Association. 1904;16:110-111.
3. Dyer, GA. Phil's Philosophical Pearls. Philip C. Anderson, MD Roast at Fall Clinics in Dermatology, University of Missouri-Columbia, 22 September 1989.

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Radiology Quiz

Roger A. Francis, MD, FACR
Diagnostic Imaging Department
Nevada Regional Medical Center

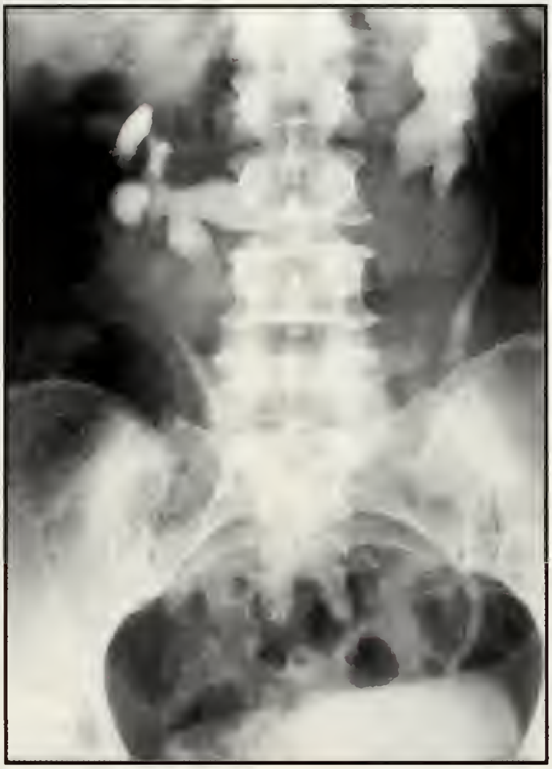

Figure 1

A 44-year-old female presented to the clinic with a history of low back pain of several weeks duration. Urinalysis was reportedly normal. An intravenous urogram was performed with injection of 100 ml of Optiray 300 mg/ml. A 10 minute film is submitted (Figure 1).

1. **What is the most likely diagnosis**

   a. Ureteral calculus
   b. Congenital megacalyces
   c. Horseshoe kidney
   d. Renal cell carcinoma

(See answer on next page.)

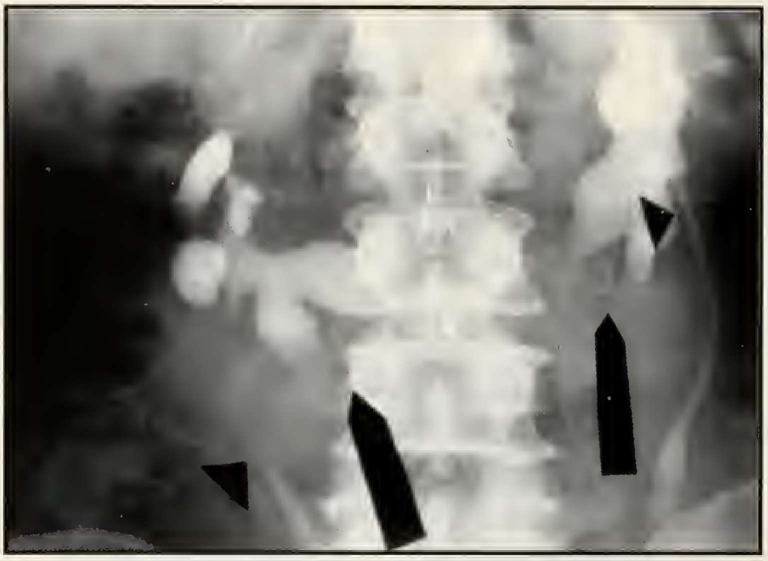

Figure 1 repeated

ANSWER

c - Horseshoe kidney

The intravenous urogram shows an abnormal orientation of both renal collecting systems (Figure 1 repeated). Instead of the normal orientation with lower poles of the kidneys slightly more lateral than upper poles, the lower poles in this case are directed medially (arrows). Also, ureters are noted to exit the kidneys anteriorly and slightly laterally (arrowheads) rather than the normal medial exit point of the ureters. Renal calyces are moderately dilated bilaterally, but no masses are seen, and no unilateral ureteral dilatation is seen. The above findings are characteristic of horseshoe kidney anomaly.

Horseshoe kidney is one of the more common anomalies of kidney development, and apparently is caused by fusion of nephrogenic cords as the kidneys begin their normal developmental ascent out of the fetal pelvis. This fusion prevents normal medial rotation of the kidney so that the ureters exit anteriorly over the fused renal mass, which may be functioning or nonfunctioning tissue. Much of the renal collecting system is extrarenal, and may appear dilated without being obstructed. When the bridging tissue is not apparent on intravenous urography, other imaging modalities including ultrasonography or computerized tomography may demonstrate the renal tissue bridging the kidneys anterior to the aorta and inferior vena cava. Turner's syndrome and trisomy 18 are frequently associated with horseshoe kidney, but most cases of horseshoe kidney are isolated anomalies.

Ureteral calculus is unlikely since collecting system dilatation is bilateral, and no ureteral dilatation or opaque stone is seen.

Congenital megacalyces is another kidney anomaly which may be unilateral or bilateral. This is caused by hypoplastic medullary pyramids which fail to cause the normal cup shaped impression on the calyces, but instead show a polygonal or mosaic shaped calyceal appearance. This anomaly would not cause the abnormal orientation of the renal axes as seen in this case, and is therefore unlikely.

Renal cell carcinoma usually presents as a mass which results in displacement or distortion of the collecting system of one kidney. This would be unlikely to cause the unusual orientation of the kidneys in this case, and lack of a visible renal mass in this case make renal cell carcinoma unlikely. **MoMed**

Reference:

Taveras JM, Ferrucci JT. *Radiology: Diagnosis-Imaging-Intervention*, Lippincott Raven 1998, Vol 4, Chpt 108, pp 1-20.

Erythema Chronica Migrans (ECM)

Ticks and Lyme Disease in Missouri

Ronald W. Swinfard, MD and Philip C. Anderson, MD

The diagnosis of annular erythemas of the skin is not so simple as assumed in the many medical articles about Lyme disease.[1,2] Erythema chronica migrans (ECM) is not a unique flag for Lyme disease. Experience in Missouri with tick bites can help us to understand this issue. We present a historical review of the classification of the figurate erythemas of the skin to show the many ambiguities, assumptions, and imprecisions that remain still today and clutter every understanding of the annular erythemas.

At a dermatologic meeting in Sweden in the late summer of 1909, Afzelius presented a patient who had a fixed annular erythema around a tick bite.[3,4] He named this disorder, erythema migrans (later, in his articles he wrote "erythema chronica migrans" or ECM), although even in 1900, this term had been batted around for some variants of mild erythema multiforme, and for the disease that we call erysipeloid today. "ECM" was even used for some gyrate erythemas of the tongue that, today, we might diagnose as geographic tongue.

To better understand the logic behind the morphologic diagnosis of annular erythemas in the formative 1910-1920 period, the reader might review the first chapter in Sigmund Pollitzer's 1920 translation of Darier's textbook.[5] In brief, to the experts, many dermatologic diseases are annular, notably syphilis, but also tinea, psoriasis, lichen planus, sarcoidosis and granuloma annulare. One subset of the annular erythemas must initially be pure erythema, and edema, that is, primary vascular lesions. The classic examples are urticaria, erythema multiforme and erythema marginatum of rheumatic fever. Annular urticaria and erythema marginatum are transient, or evanescent.

Persistence in one place over days defines urticarial vasculitis, erythema multiforme, and fixed drug reactions, among others. To distinguish these persisting lesions, Darier added on the name "chronica" or "perstans." Some of the erythemas remain the same size and shape as when they first appear and throughout their entire course; these may be called "fixed," as are fixed drug reactions. Working in this tradition of naming, Afzelius wanted to describe a papular erythematous reaction beginning around a wound from a tick bite, that migrated out (migrans) to assume a gyrate annular form that then remained in place (chronica) for weeks, and so he chose "ECM." Understandably, no one was much impressed. As Pollitzer points out, experienced dermatologists had seen this rash around a wound caused by various bites or stings from many arthropods and insects (notably, ticks, lice, bedbugs, and chiggers), around punctures by various spines or spicules, and some other injuries.[6,7,8,9] The term "ECM" was no improvement over just "annular erythema." No one was surprised by the concept later that ECM might represent some sort of systemic infection because annular erythemas already were well known to occur in syphilis. Neither was the idea considered unusual that a disease might be transmitted by an arthropod bite, because they knew about malaria and yellow fever. But they were well aware that most all of the annular erythemas they saw around punctures were trivial and did not indicate any systemic disease at all, but were just complex, self-limited reactions to injuries. There was nothing distinctive about ECM.

In the mid-1950s in Ann Arbor, Michigan, I (PCA) saw ECM in a co-resident arising from chigger bites, but no one then preferred to use that term. After 1962, at the University of Missouri, I saw many examples of ECM from tick bites on our own faculty members and their children, among other patients. I had adopted from the literature the idea that a rickettsia might cause such a reaction, but I could find no evidence for that idea either clinically or by biopsy or by simple laboratory examinations. I did follow these cases carefully looking for a late blooming rickettsiosis. These patients, some of whom I saw everyday, all remained entirely well. My hypothesis was set aside. We have continued to see many such cases of ECM from tick bites regularly over the last 36 years, still none with Lyme Borreliosis.

In 1976, Steere discovered that some children who had been erroneously diagnosed as juvenile rheumatoid arthritis, actually had a tick-transmitted spirochetosis, now called Lyme disease and caused by Borrelia burgdorfii.[10] In many of these cases, around the causative tick bite was an annular erythema of ECM pattern, migrating out from the puncture and then persisting for a few weeks as a gyrate erythema. The term "ECM" was quickly recalled and enormously publicized.

The clinical facts remained the same, however. Typical ECM still occurred mostly without any spirochetosis, or without any tick bite at all. The cutaneous lesion was not exclusive to Lyme disease, not pathognomic of any one disease. Consider Steere's Lyme disease in mid-Missouri. The ticks that actually transmit Lyme disease are found only in a few U.S. locations, mostly in northeastern coastal states (Massachusetts down to Maryland), along the northern edge of the Midwest (Minnesota and Wisconsin) and in Oregon and California. But the causative spirochete together with the tick have been found in only 14 of our 50 states. Most states do not have any original cases of the tick-borne borreliosis of the type Steere discovered. Lyme disease does not occur naturally in mid-Missouri,[11] but ECM does occur commonly in Missouri. ECM originating in Missouri can not be linked to Lyme disease or even, exclusively, to the bites of ticks. These long-standing, well-verified observations help to clarify the issues.

No medical group was more pleased than dermatologists to have one better-elucidated etiology for ECM, however, in this enthusiasm we must avoid over simplifications.[12] Diagnosis remains complex.[13,14,15] One concern is that we have no knowledge about cutaneous reactions to the bites of sterile ticks, which is an essential control group in the proper study of tick bites. Next the classification of borrelia organisms remains unfinished, and details of other borrelioses are incomplete. Other tick bite diseases or true borrelioses yet may be found.[16]

Semantics are important. We prefer the term Lyme borreliosis for the disorder Steele described. We must avoid including under "Lyme disease," obscure fevers, fibromyalgia, chronic fatigue syndromes, or neurologic disorders.[17] In most states in the U.S., it is not advisable to treat ECM with antibiotics as if it were Lyme borelliosis, without better evidence. Some surveys estimate that 60% or more of the presumed cases of Lyme borreliosis are misdiagnosed.[18] ECM easily pushes the physician to an erroneous diagnosis. Clarifying the implications of ECM is important and the long-time clinical experience in Missouri is wholly relevant. Our state is rich in ECM, but thankfully, not in Lyme borreliosis. MoMed

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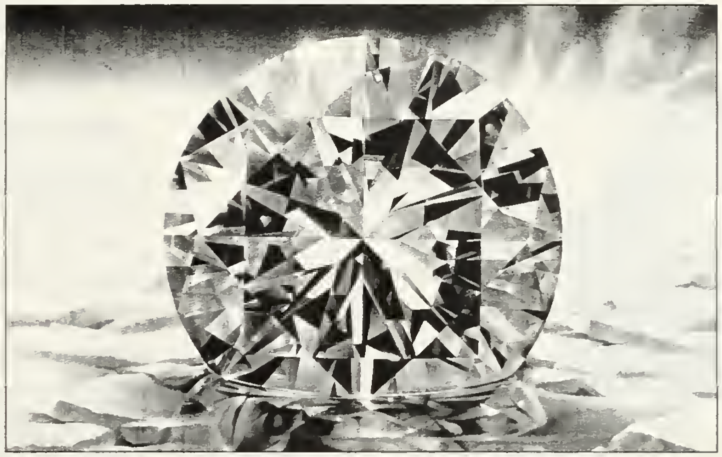

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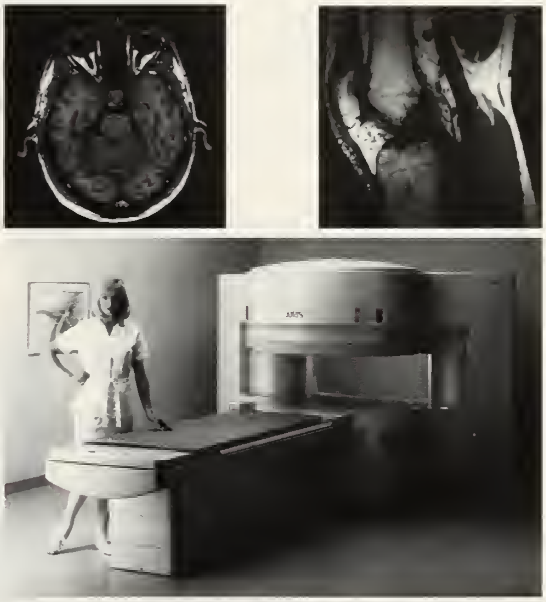

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Octavio R. Chirino, MD, St. Louis, has been named Interim Chair of the Department of Obstetrics and Gynecology at St. John's Mercy Medical Center. He is a member of the MSMA Council.

Lester Bryant, MD, former dean of the University of Missouri-Columbia School of Medicine, shares his perspective on being a successful dean in the new book, "The Medical School Dean: Reflections and Directions." Dr. Bryant contributed one chapter entitled "Thirteen Years of Deaning: Lessons Learned, and a Few Relearned," which details some of his personal observations on being a successful medical school dean.

M. Scott Beall, Jr., MD, Kansas City, has been elected to the Board of Councilors of the American Academy of Orthopaedic Surgeons and of the American Association of Orthopaedic Surgeons. Dr. Beall is clinical instructor, department of orthopaedics, University of Kansas Medical Center and is in private pratice at Carondelet Orthopaedic Surgeons, PC.

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Joplin, MO 64804
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NORTHEAST

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Hannibal, MO 63401
Univ of WI Med School-Madison 1984

OZARKS

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10 - *St. Louis:* **Musculoskeletal Radiology.** Call Mallinckrodt 314-362-7130.

14 - *St. Louis:* **Child and Adolescent Psychiatric Disorders.** Call Washington University 800-325-9862.

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June

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4 & 5 - *St. Louis:* **Neurosurgical Endoscopy.** 14 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

6 - *St. Louis:* **Endoscopic Release of the Carpal Tunnel.** 6 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

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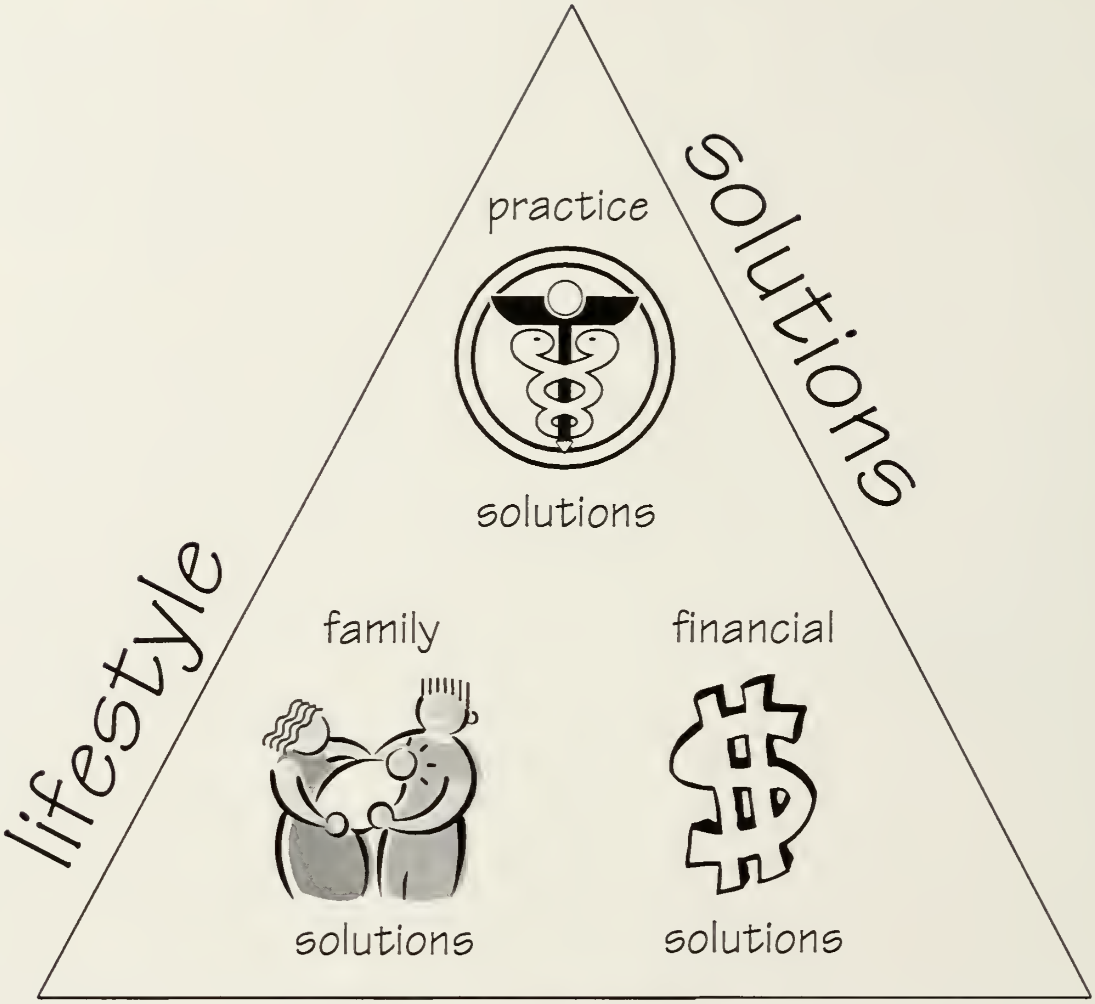

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On the Cover: "Spring-Iris No. 12" - by Jean Campbell, MD, Cape Girardeau. This pastel on paper was the winning entry at the MSMA Art Contest held in conjunction with the 141st Annual Convention. For more information about Dr. Campbell, see page 201.

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Presidential Address by Stephen Vilmer, MD

MISSOURI
STATE MEDICAL
ASSOCIATION
Dr. Dolla

The following Presidential Address was given by Stephen Vilmer, MD, during the First Session of the House of Delegates at the Tan-Tar-A Resort in Osage Beach, Missouri.

Good morning and welcome.

I'm Steve Vilmer, your MSMA President. Welcome to the one hundred forty-first Annual Convention of the Missouri State Medical Association.

In the next few days this House of Delegates will debate, deliberate, and then decide a course of action for the coming year. Although we will work, we will also play. We will renew old friendships, but find new meaning in our alumni reunions. Don't forget the Exhibit Hall, and take the opportunity to visit with the exhibitors who support our meeting.

Reports before you will tell where we've been, and resolutions you consider will determine where we're going. Hopefully, we'll all have learned from sessions aimed at "Preserving the Physician-Patient Relationship in the Managed Care Environment."

And by this time on Sunday morning, we will have traveled far, but along the way found new leadership to take this MSMA into the next century.

Again, welcome – I'm glad you're here.

It would be folly for me to come before you and say that I can summarize the past year's activities of your MSMA. The plate is full – where do I start, and where do I end? Perhaps we should see where we've come from, and where we're going. Even now, several projects are underway responding to the ever-changing face of health care in Missouri. However, I can point to three "absolutes" in the Missouri State Medical Association. First, it's absolutely true that MSMA does not have an internship program. Likewise, no one is employed at MSMA with the name of Monica. And finally, it's true that the MSMA President is not overpaid.

Our long-standing relationship and endorsement of the Missouri Medical Insurance Company, MOMEDICO, will come to an end in mid-August. The business interests of that company and our Association are now divergent. And so too, the Physicians Resource Network has struggled, and finally been put to rest.

It should be said that the MSMA Council is currently exploring several innovative programs to attract new members, and give each MSMA member more value for the dues-paying dollar. Through the purchasing power of our numbers, we hope that quality malpractice insurance can be offered with premiums substantially below market rates. And if that product is made available only to MSMA members, then you and I will benefit not only from less practice overhead, but also enjoy a state medical association with a larger membership. In turn, that will keep our dues affordable. And don't for one minute accept your colleague's retort that MSMA's dues are too high. Remember, at $300 per year, your MSMA dues are second lowest in the nation. Quite a bargain, and worth every penny. Even so, your MSMA must be innovative in retaining present members and adding new ones. Resolution #4 in

Reference Committee B is offered for your consideration. Hopefully this House of Delegates will agree that it's time to explore dues incentives that make physicians want to be members of MSMA. And while we're talking about membership, I commend the new student chapter at the University of Health Sciences in Kansas City. These are leaders of the medical world of tomorrow, realizing the value of MSMA membership today.

With over 6,000 members, the MSMA continues as the largest organization in Missouri representing physicians in the quest for quality health care. Working relationships continue with the Board of Healing Arts, the Missouri Hospital Association, the Missouri Patient Care Review Foundation, the Missouri Association of Osteopathic Physicians and Surgeons, and numerous branches of state government, such as the Departments of Health and Insurance, and of course, the Legislature.

Just think, if this medial association gave nothing more than legislative representation, MSMA membership would still be worth it. To think of it another way – what would Missourians have for health care if MSMA weren't there? What would medical practice look like for Missouri physicians if the MSMA weren't there. Let's see!

There would be absolutely none of the many provisions of House Bill 335, the Managed Care Reform Bill of 1997. There would be no protection afforded by the Chronic Pain Act, or the Prompt Pay Bill which went into effect just last week. And physicians would not be receiving that Medicaid fee increase, the first one in twenty years. But, you'd be paying more to stay in practice because you'd be paying a "user's fee" to see Medicare patients.

Even now, there are clouds on the horizon – think of the disaster waiting to happen because of proposals currently before the Legislature. Mr. Tom Holloway went to the heart of the problem when he said: "There are two ways to practice medicine in Missouri – either go to medical school, or go to the Legislature."

What will happen if naturopaths are doing surgery? What happens when anesthetists are administering anesthesia without supervision of the anesthesiologist? What happens when physical therapists institute treatment without your prescription? What happens when psychologists are prescribing controlled substances? And what will happen when pharmacists are allowed to prescribe medications, or alter your prescriptions? Does MSMA need to work with the Legislature, and does the Legislature need the MSMA. I think the answer is obvious.

In present times, managed care, or managed money – if you will – permeates our practices and the lives of many of our patients. MSMA will soon be launching a six-month campaign to further educate the public on their rights when dealing with managed care. This effort will include patient education brochures, 14 outdoor billboards across the state, 7,856 radio spot announcements, talk show interviews with MSMA physicians and information on the MSMA website.

But when there is egregious interference with the doctor-patient relationship, MSMA will make a frontal assault. Winston Churchill said: "We shall go on to the end. We shall fight on the seas and the oceans. We shall fight with growing confidence and strength in the air. We shall defend our island, whatever the cost may be. We shall fight on the beaches. We shall fight in the fields and in the streets. We shall fight in the hills – we shall never surrender."

So, when Blue Cross Blue Shield of Kansas City imposes a mandatory program for hospitalists. MSMA will take a stand. When Aetna Insurance Company provides the money to develop medical school curricula on managed care, MSMA will take a stand. And when managed care contracts are designed to strip the physician of all rights, MSMA will take a stand.

Now I have had the privilege of giving you a brief sketch of what your Missouri State Medical Association has been doing. But the credit really goes to many people. The Committees and Commissions, the Council and Executive Committee deserve your thanks and mine. And the MSMA staff puts it all together and keeps us on track.

As I near the end of my Presidential year, I extend my personal thanks to all of these people and to all of you. Dr. Don Fakhoury can now breathe easy, as I have survived and he has not been forced into office.

It's been a full year, and a fun year. Thank you. **MoMed**

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William Dorzab, MD, Installed as the 1999-2000 MSMA President

The following is the Presidential Inaugural Address given by Dr. Dorzab, April 10, 1999, at the Tan-Tar-A Resort in Osage Beach, Missouri.

A Tale of a Profession

Tonight... I want to give you a perspective on our profession.

The year is 2050. A middle-aged man keeps an appointment with his physician.

We cannot know how he traveled to the appointment – for modes of transportation will have undergone unimaginable changes.

We cannot know what tests his physician will offer him – for the Science of Medicine will have progressed beyond the vision of our crystal ball.

We cannot know the therapeutic modalities the patient will choose for the Art of Medicine will have surpassed our wildest dreams.

But, as sure as we sit here this evening, we can know what the two most important pieces of equipment in the physician's office are: two chairs – one for the patient and another for the physician.

For thousands of years, a physician – face to face with a patient – has been the indispensable formula for trust, confidence, and an expectation of therapeutic success.

Medical care has been a prominent part of social fabric throughout history.

Sickness and injury have always been with us. As early civilizations developed – probably along the Nile in Egypt; the Tigris and Euphrates in the Middle East; the Indus in India and the Yellow River in China – a few became known for mastery over disease. They had some ability to predict and alter its course.

Their tools were limited, but these early members of our profession did just as we do today. They used the tools they had and they did what they could to alleviate pain and suffering.

Beliefs about the causes of disease have changed over time. Initially, afflictions were understood to be expressions of the wrath of gods.

Shaman priests recommended offerings, sacrifices, penances, and more than a little magic was worked into the potion.

Gradually other – and hopefully improved – therapies crept into the armamentarium. Serendipitous experiences, anecdotal accounts, and finally scientific inquiry were instruments of discovery.

A fluid mixture of the spiritual, the mystical, and increasing amounts of the "scientific" worked its way through the centuries.

To better understand how medicine related to other institutions down the centuries, picture our profession as a great serpent, perhaps one of the snakes of the Caduceus winding its way through time.

The center and direction of the reptile are steady and true, anchored by superior ethical underpinnings and proud traditions.

Along the travel through time, institutions and governments interact with our medical serpent and try to modify it for their own purposes.

But its course is largely unaffected, steered by tradition, principle, ethics, and the physicians of the day.

The history of medicine is brimming with notable individuals. Maimonides, Hippocrates, Jesus of Nazarus, Paracelcus. All are renowned healers.

But what is it about any and all physicians that preserves our profession?

When a physician and a patient face each other – whether it be in 1999 or 1699 – an extraordinary milieu of confidence and expectation surrounds and binds them.

That physician/patient relationship, bolstered by powerful ideas and centuries of tradition, trust, and consistency, is unique and a vehicle that can be driven only by the fully trained physician.

In spite of governments, payers of health care fees, managers of health care services, to intercede.

Only those trained in the Hippocratic tradition, can hope to master the blend of art and science demanded in the physician/patient relationship.

Our medical profession has a timeless aspect.

Its basic tenets and ethical underpinnings render it impervious to influences that would damage other lesser institutions.

To be sure, medicine can be challenged or even threatened.

In antiquity many a shaman priest lost his life for failing to save the king.

Physicians in Nazi Germany yielded to social and political pressures to participate in medical atrocities such as accepting the concept of lebenunvertes Leben (life unworthy of life).

Psychiatrists in the former U.S.S.R. provided bogus mental illness diagnoses as a precept for incarcerating political dissidents.

Physicians in Canada have largely seen no alternative but to try to make a government-imposed system work for their patients even if, as some believe, rationing may be a result.

Some managers of health care delivery in France are accused of releasing HIV-tainted blood components apparently due to cost concerns.

This audience is most familiar with the problems of our time and in this country.

It would be tedious to this knowledgeable audience for me to give a comprehensive list of today's challenges.

Suffice it to say that the combination of big business – a capitalistic economy – and government have produced an environment where many physicians find it difficult to observe the ethics and principles of their profession in a way they find satisfactory.

Challenges to our profession are not unique to the present.

As our serpent winds its way through history, nations, governments and other institutions come along for short rides.

They often challenge our ethics and principles. Eventually they drop off into history often into oblivion after running their course.

The earliest archeological evidence of social medical activity is over 10,000 years old.

Many of the principles we now hold dear originated before Christ.

How many dictators, democracies and, yes I guess we can now add insurance companies, have come and gone, while the Medical Profession worked its way carefully through history?

Most would agree that these are not the worst of times. Few contemporary physicians have lost their lives for failure to cure.

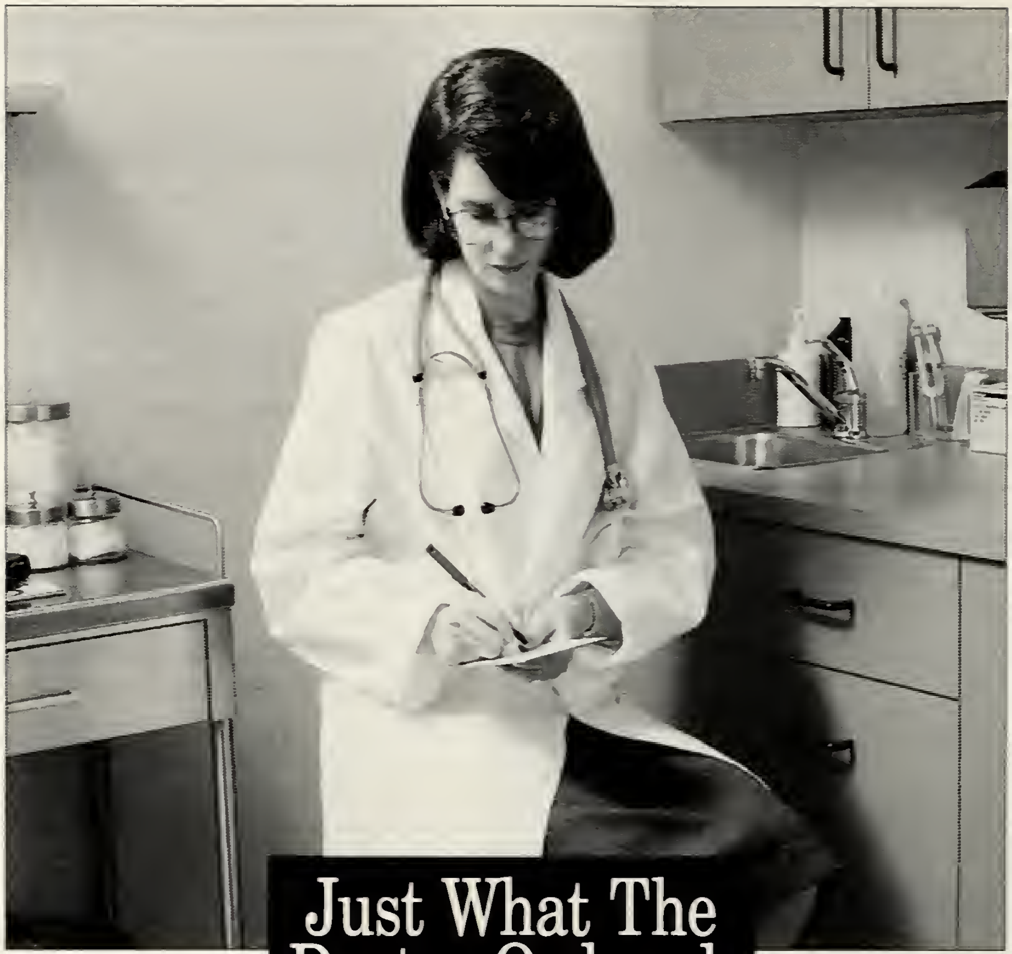
But these are also probably not the best of times.

One thing is certain – these are the only times we will shepherd.

We, the physicians of this time, our time, have the obligation to meet the enemies, resist them, and leave our beloved profession in good condition for those who will come after.

This is why we meet this weekend, for it is largely through the Federation of Medicine, including the Missouri State Medical Association, that contemporary American physicians carry out this sacred obligation all the while giving today's patients the best medical art and science have to offer.

As that important contemporary philosopher, Yogi Berra, once said: "I just want to thank everyone who made this day necessary." **MoMed**



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Minutes of the House of Delegates

Introduction

The 141st annual meeting of the Missouri State Medical Association was held at the Tan-Tar-A Resort in Osage Beach, Missouri, April 8-11, 1999, with John Rollo, MD, presiding as Speaker of the House of Delegates. Carol Williams, MD, Committee on Credentials, announced there were seven Officers, 27 Councilors, and 55 Delegates in attendance for the opening session of the House. This report and the minutes of the 140th Annual Convention as published in the June 1998 issue of *Missouri Medicine* were approved. At the second session of the House of Delegates, Dr. Williams reported seven Officers, 32 Councilors, and 137 Delegates were in attendance. During the third session of the House, Dr. Williams reported eight Officers, 32 Councilors, and 152 Delegates. The final two reports were adopted.

Reference Committees

The speaker announced the members of the Reference Committees as follows: *Reference Committee A* - Larry Handlin, DO, Chair, *Mexico;* Kirby Turner, MD, *Poplar Bluff*; Larry Rues, MD, *Kansas City*; William Turner, MD, *Nevada*; and Bruce Walz, MD, *St. Louis*. *Reference Committee B* - Joni Scott, MD, Chair, *Rogersville*; George Hubbell, MD, *Osage Beach*; Loretta Loftus, MD, *Kansas City*; Richard Martin, MD, *Cape Girardeau*; Stephen Slocum, MD, *St. Louis*.

Nominating Committee

Dr. Vilmer appointed the following members to the Committee on Nominations:

District 1	Gary Dyer, MD, Chair; *St. Joseph*
District 2	Sandra Ahlum, MD; *Hannibal*
District 3	David Wilkinson, MD; *St. Louis*
District 4	Jeffrey Copeland, MD; *St. Peters*
District 5	Kenneth Rall, MD; *Columbia*
District 6	William Turner, MD; *Nevada*
District 7	Carl Strauss, MD; *Kansas City*
District 8	James Wolfe, MD; *Springfield*
District 9	Hugh Bartlett, MD; *Rolla*
District 10	Richard Martin, MD; *Cape Girardeau*
OMSS	A.J. Campbell, MD; *Sedalia*
YPS	Sam Page, MD; *St. Louis*
MSS	Mr. Wildon Farwell, *Columbia*

Election by the House of Delegates

Officers

President-Elect
Gordon Goldman, MD; *St. Louis*

First Vice President
Robert T. Gibbons, Jr., MD; *Overland Park, KS*

Vice Presidents
David Barbe, MD; *Mountain Grove*
Meredith Payne, MD, *St. Louis*

Speaker of the House of Delegates
John Rollo, MD; *St. Louis*

Vice Speaker of the House of Delegates
Edwin Masters, MD; *Cape Girardeau*

AMA Delegates
Robert T. Gibbons, Jr., MD; *Overland Park, KS*
William Huffaker, MD; *St. Louis*
H. Peter Ekern, MD; *Mexico*

AMA Alternate Delegates
Gary Dyer, MD; *St. Joseph*
James Wolfe, MD; *Springfield*
Ms. Kim Nestor, *Kansas City*

MSMF Board of Directors
Robert Schaaf, MD; *St. Joseph*
Frederick W. Hahn, MD; *Independence*
Stephanie Womack, MD; *Columbia*

Stephen Vilmer, MD, presents Robert Tanner, MD, with a clock to honor him for his 25 years of service as Secretary/Treasurer for the Missouri State Medical Foundation.

Councilors and Vice Councilors

District 2

Councilor .... Carl Kruse, MD
Vice Councilor .... Lent Johnson, MD

District 3

Councilor .... John Anstey, MD
Edmond Cabbabe, MD
K. Lynne Moritz, MD
David Wilkinson, MD

District 4

Councilor .... Sammy Farrell, MD
Vice Councilor .... Jeffrey Copeland, MD

District 6

Councilor .... Jerry Meyer, MD
Vice Councilor .... Phillip Hornbostel, MD

District 7

Councilor .... Linda Dorzab, MD

District 8

Councilor .... Clarence Martin, MD
Vice Councilor .... Michael Hoeman, MD

District 10

Councilor .... Thomas Sparkman, MD
Vice Councilor .... Kirby Turner, MD

Organized Medical Staff Section

Councilor .... Luis Anglo, MD
Vice Councilor .... Peggy Barjenbruch, MD

Young Physician Section

Councilor .... Joni Scott, MD
Vice Councilor .... Larry Handlin, DO

Resident Physician Section

Councilor .... Jordan Page, DO
Vice Councilor .... Carolyn Morris, MD

Medical Student Section

Councilor .... Mr. Ben Unger
Vice Councilor .... Ms. Kim Schmidt

Constitutional Changes

The House of Delegates approved the Young Physician Section constitution changes tabled from the 1998 Annual Convention.

Resolutions

The following resolutions were considered at the second session of the House of Delegates. The action that was approved follows each resolution.

SUBSTITUTE RESOLUTION #1
(FOR RES. 1 & 30)

"Tobacco Settlement"

RESOLVED, the MSMA encourages the Missouri General Assembly to earmark the tobacco settlement revenue to be utilized in the prevention and cessation of tobacco use, and be it further

RESOLVED, that MSMA recommends this money be made available to individual communities under the guidance of the Missouri Department of Health, but with as few restrictions as possible to encourage innovation in community approaches to the most preventable cause of death in our nation today.

Action: **Adopted**

RESOLUTION #2

"Coverage for Treatment of Patients Whose Injuries are the Result of Suicide Attempts"

RESOLVED, that the insurance industry, including managed care plans, should provide coverage for treatment of patients whose injuries are the result of suicide attempts, and be it further

RESOLVED, that MSMA pursue a resolution to this problem including, if necessary, changes in state statutes.

Action: **Adopted**

RESOLUTION #3

"Year 2000 Computer Problem"

RESOLVED, that the Missouri State Medical Association work with Missouri state government on the Year 2000 computer problem to ensure the citizens of Missouri will be able to receive uninterrupted health care services.

Action: **Adopted**

RESOLUTION #4

"MSMA Council Establish Dues Amounts, Incentives and Pilot Projects"

RESOLVED, that the responsibility for establishing dues amounts, dues incentives and pilot projects be transferred to the MSMA Council by adoption of the following changes in the MSMA Constitution and Bylaws:

MSMA Constitution

Article IX. Funds, Expenses and Budget

The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

MSMA Bylaws

Chapter XIII. Dues and Assessments

Section 1. (a) The annual dues of this Association shall be set by the Council and payable by January 1 of the year for which they are levied.

Action: **Adopted**

RESOLUTION #5

"Young Drivers"

RESOLVED, that the MSMA support efforts to insure that all young drivers die of old age with help of the following three-step approach:

1) Permit 16-year-olds to drive with a parent or responsible adult for six to twelve months.
2) Permit 17-year-olds to drive by themselves.
3) License 18-year-olds without violations or accidents.

Action: **Referred to MSMA Council**

AMENDED RESOLUTION #6

"Creation of a Model for Collective Negotiating with Health Plans on Patient Care Issues Other than the Amount of Financial Reimbursement by the American Medical Association and State and Local Medical Societies"

RESOLVED, that the American Medical Association, the Missouri State Medical Association, and constituent local medical societies develop a model for collective negotiating with health plans on patient care issues which are of vital importance to physicians and their patients but which do not concern the actual amount of financial reimbursement and would not violate antitrust laws, and be it further

RESOLVED, that the development of this model be a high priority item, and be it further

RESOLVED, that this resolution be submitted for consideration by the AMA House of Delegates at the A-99 meeting

Action: **Adopted**

MSMA member, Eugene Worth, MD, MEd, of Medical Information Technologies presented "Y2K: Practical Tips on How You Can Survive."

RESOLUTION #7

"Third Party Payer Cover Point of Service Patients the Same as Provided HMO Patients for Emergency Medical Coverage"

RESOLVED, that MSMA propose legislative and/or rule changes requiring third party payers to cover their point-of-service patients in case of "emergency medical condition" as defined in RSMo Chapter 354.600(3) the same way they cover their regular HMO patients by waiving the patient's additional financial responsibilities if they received their emergency treatment in a facility not part of their plan or received their care by a physician who is not a participant in their network.

Action: **Adopted**

AMENDED RESOLUTION #8

"Recruitment of Former Members"

RESOLVED, that the MSMA shall contact through a mailing specially formulated for this purpose all past active members who still qualify for said membership status under existing regulations, to invite them to return as active members of MSMA, and be it further

RESOLVED, that all past MSMA dues will be waived and the member shall return to active status with the original date of participation in his/her membership files, and be it further

RESOLVED, that a list of said colleagues being invited to rejoin the MSMA as active members be forwarded to every MSMA component society so that additional efforts at recruitment can be considered at this level, and be it further

RESOLVED, that this program be on a trial basis.

Action: **Adopted**

RESOLUTION #9

"Disclosure of Corporate Ties Affecting Formulary Choices and Drug Substitution"

RESOLVED, that the MSMA petition the AMA to request full disclosure to patients and physicians at the time of refill any corporate ties between pharmaceutical companies, mail order pharmacies, and formulary management groups, including a list of all medications on the formularies that are manufactured or distributed by the parent pharmaceutical manufacturer, and be it further

RESOLVED, that the MSMA petition the AMA to request that insurance companies and their formulary management groups inform the patient as to why their medication is being changed and that any change other than generic requires authorization by their physician.

Action: **Referred to MSMA Council**

AMENDED RESOLUTION #10

"Proposed Health Care Integrity and Protection Data Bank Include Only the Names of Physicians who have been Involved in Adjudicated Actions"

RESOLVED, that the AMA insist that no physician's name or offense be listed in the Health Care Integrity and Protection Data Bank unless such physician either does not contest the allegation of fraud or is found guilty in a court of law where he or she has the same due process rights accorded to all other U.S. citizens on other adjudicated actions or decisions, and be further

RESOLVED, that if the AMA's negotiations with HCFA and appropriate agencies fail to achieve the above, the AMA seek federal legislation to gain protection for physicians, and be it further

RESOLVED, that this resolution be submitted to the A-99 meeting of the AMA House of Delegates.

Action: **Adopted**

AMENDED RESOLUTION #11

"Physician Protections in Fraud Data Bank Program"

RESOLVED, that physician payments to HCFA in Medicare billing disputes will not be alleged fraud on the basis of statistical profiles or extrapolation, and be it further

RESOLVED, that any allegation of fraud can only be made after considering the specific patient situations and physician intent which generated the alleged fraudulent bills, and be it further

RESOLVED, that the peer review by physicians be used in the consideration of alleged fraudulent billing, and be it further

RESOLVED, that before claims of fraud can be made public against physicians that physicians have the same rights to due process afforded to any other citizens, and be it further

RESOLVED, that the MSMA ask the AMA to seek national legislative guarantees of the above if the AMA's negotiations with HCFA, OIG, and the U.S. Attorney fail to achieve the above.

Action: **Adopted**

RESOLUTION #12

"Computer Access to CME"

RESOLVED, that as part of the CME credentialing criteria, it is recommended that all syllabus materials and/or oral presentations, which includes text, tables, figures and graphics, be made available on standard personal computer electronic media for those who attend CME programs, where a registration fee is required, and be it further

RESOLVED, that this principle be carried forward by MSMA to the AMA at its next meeting of the House of Delegates for incorporation as a national standard for CME accreditation.

Action: **Not Adopted**

RESOLUTION #13

"Insurance Regulations"

RESOLVED, that insurance companies must honor premium estimates for three years.

Action: **Referred to MSMA Council**

RESOLUTION #14

"Patient Costs"

RESOLVED, that health insurance organizations be held accountable for insuring that charges to patients are lower by using insurance plans than by paying outright for healthcare services, and be it further

RESOLVED, the copayment for prescriptions should be regulated for $2 for amounts under $10 cost, $4 for costs $10 to $20, and, thereafter, a percentage stated in the health insurance policy.

Action: **Referred to MSMA Council**

RESOLUTION #15

"Corporate Relations"

RESOLVED, that the Missouri State Medical Association's Executive Vice President is responsible for the review and implementation of each specific corporate arrangement according to the AMA's set of principles and the Mission Statement of the MSMA, and be it further

RESOLVED, that the Missouri State Medical Association's Executive Vice President is responsible for informing the MSMA Executive Committee and/or Council so that they may approve and authorize corporate arrangements that have an economic and/or policy impact on MSMA.

Action: **Adopted**

AMENDED RESOLUTION #16

"Home Health Costs"

RESOLVED, that Medicare supply physicians with durable medical equipment and home health care services reports to allow physicians to understand the charges associated with services authorized, and be it further

RESOLVED, that the Missouri State Medical Association request the American Medical Association to address this issue with the Health Care Financing Administration.

Action: **Adopted**

AMENDED RESOLUTION #17

"Universal Referral Form"

RESOLVED, that practitioners within the State of Missouri may submit a Universal Referral Form, without penalty, in lieu of a specific form developed by the company for the referral process, and be it further

RESOLVED, that insurers may not delay or otherwise compromise the referral process solely because the referral request is made with the Universal Referral Form rather than the company's own form, and be it further

RESOLVED, that MSMA continue to support the concept of the Universal Referral Form.

Action: **Adopted**

AMENDED RESOLUTION #18

"Drug Formularies"

RESOLVED, that any MCO or insurance company which distributes a drug formulary to health care providers or pharmacists must, in addition to paper copies of such formulary, also distribute as electronic media preferably using a national standard format, and be it further

RESOLVED, that this resolution be submitted for consideration by the AMA House of Delegates at the A-99 AMA Meeting.

Action: **Adopted**

RESOLUTION #19

"AMA Web Site"

RESOLVED, that reports of the Councils, Board of Trustees, and Resolutions be posted on the AMA web site well in advance of the meeting of the House of Delegates for all members of the AMA to view, and be it further

RESOLVED, that these sites be widely publicized in all the AMA publications, and be it further

RESOLVED, that "chat areas" be created in the AMA web site for:

a) the exclusive utilization of the various state and regional caucuses so that discussions can occur on the reports and resolutions,
b) reference committee discussions by delegates and alternate delegates on the committee's material, and
c) open "chat areas" for all members to use to communicate with their delegates, alternate delegates, and the rest of the AMA leadership on the pending issues.

Action: **Adopted**

RESOLUTION #20

"AMA Internet Service"

RESOLVED, that the AMA investigate the possibility of procuring for its membership Internet access at a discounted rate.

Action: **Withdrawn**

RESOLUTION #21

"Ophthalmology-Optometry Comanagement"

RESOLVED, that the Missouri State Medical Association (MSMA) call for enactment of appropriate laws and/or regulations to assure that if "comanagement" arrangements are utilized, that the best interests of the patient are the sole reason for such arrangements, and that financial incentives between providers for making or receiving referrals clearly are illegal, and be it further

RESOLVED, that the MSMA call on the American Medical Association to seek similar laws and/or regulations at the federal level, and be it further

RESOLVED, that HCFA's existing requirement for physician travel reimbursement, being travel of 100 miles or greater, one-way, become the patient hardship requirement that is needed to submit a bona fide split care submission to Medicare, with other special circumstances being considered in writing by the surgeon's local Medicare carrier on a case by case basis.

Action: **Referred to MSMA Council**

RESOLUTION #22

"Pacemakers"

RESOLVED, that Medicare pay for pacemaker implantation at Ambulatory Surgery Centers, and be it further

RESOLVED, that the Missouri State Medical Association request the American Medical Association to address this issue with the Health Care Financing Administration.

Action: **Referred to MSMA Council**

Arthur Freeland, MD, Warrensburg, gives testimony on a resolution.

RESOLUTION #23

"Split Care (Comanagement)"

RESOLVED, that the Missouri State Medical Association propose state legislation which would serve to delineate the conditions and manner under which "comanagement" arrangements may be allowed, and be it further

RESOLVED, that this resolution be submitted to the AMA House of Delegates calling for similar regulations to be adopted nationally by the Health Care Financing Administration, a federal government agency.

Action: **Referred to MSMA Council**

RESOLUTION #24

"Provisions for Care of the Uninsured In Missouri"

RESOLVED, that the Missouri State Medical Association initiate negotiations with insurance companies in Missouri to explore private initiatives to extend insurance coverage and access to health care to all persons within the State, and be it further

RESOLVED, that the Missouri State Medical Association urge the Department of Health of the State of Missouri to conduct an annual survey of the uninsured citizens within the State, as has been done in the past, in order to provide measures of the magnitude of the problem and of progress towards the goal of ensuring access to health care for all citizens.

Action: **Adopted**

SUBSTITUTE RESOLUTION #25

"Disaster Response Task Force"

RESOLVED, that MSMA work with the State Emergency Management Agency and the Missouri Emergency Preparedness Association to address the physician component of a Disaster Response Task Force.

Action: **Adopted**

SUBSTITUTE RESOLUTION #26

"Voluntary Hospitalist Programs"

RESOLVED, that MSMA adopt the following AMA Policy:

Officers, Councilors, Vice Councilors, and Delegates take the oath of office at the third session of the House.

H-285.932 The Emerging Use of "Hospitalists"

1. AMA policy states that (a) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of "admitting officer" or " hospitalist" programs; (b) participation in admitting officer or hospitalist programs developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient's physician; and (c) hospitalist systems when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with approval of the organized medical staff to assure that the principles and structure of the autonomous and self-governing medical staff are retained.

2. That hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "Hospitalists" and that no punitive measure should be imposed on physicians or patients who decline participation in "hospitalists programs."

3. That AMA opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants. (CMS Rep. 4, A-98), and be it further

RESOLVED, that MSMA will work with appropriate Missouri agencies to ensure that new and existing hospitalist programs conform to Missouri law and will seek any legislation needed so that each element of the above AMA Policy not already enacted becomes Missouri law.

Action: **Adopted**

SUBSTITUTE RESOLUTION #27

"Antitrust Legislation"

RESOLVED, that MSMA adopt the following AMA Policy:

H-380.987 Antitrust Relief as a Priority of the AMA

The AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association. (Sub. Res. 223, A-93; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97)

H-385.973 Collective Negotiations

It is the policy of the AMA to seek amendments to the National Labor Relations Act and other appropriate federal antitrust laws to allow physicians to negotiate collectively with payors who have market power. (Res. 95, A-90; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97)

Action: **Adopted**

RESOLUTION #28

"Blood Donations from Correctional Institutions"

RESOLVED, the MSMA should explore the development of a policy which would establish an organized program of blood donations by the prison population.

Action: **Referred to MSMA Council**

RESOLUTION #29

"Young Physician Involvement"

RESOLVED, that the local component medical societies, MSMA, and the AMA should investigate and find out what the needs are of this generation to get involved, and participate in organized medicine, and be it further

RESOLVED, that the local component medical societies, MSMA, and the AMA formulate and create programs, according to their needs and interests, and be it further

RESOLVED, that this Resolution be forwarded to the OMSS AMA Assembly and the AMA House of Delegates at the A-99 meeting.

Action: **Adopted**

RESOLUTION #30

"Tobacco Settlement"

See Resolution #1.

RESOLUTION #31

"Physicians Health Committee"

RESOLVED, that Chapter VII, Section 1, of the MSMA Bylaws be amended to read:

> The Physicians Health Committee shall consist of members of the Association appointed by the President for a term of three years. The Physicians Health Committee shall plan and execute programs of professional assistance for members of this Association who may require assistance to continue or return to their professional activities.
>
> The Committee shall evaluate, maintain, or monitor the quality and utilization of health care services or exercise any combination of such responsibilities of the members of the program.

Action: **Adopted**

SUBSTITUTE RESOLUTION #32

"Location of Annual Convention"

RESOLVED, that in an effort to increase member attendance at the Annual Conventions, it is recommended that the convention dates and places be rotated between St. Louis and Kansas City, beginning the Year 2000, and be it further

RESOLVED, that the MSMA Council continue to investigate suitable alternative locations for the Annual Convention and report back to the House annually.

Action: **Adopted**

AMENDED RESOLUTION #33

"PRIMO Funds"

RESOLVED, that the Missouri State Medical Association urge our State Legislature to increase funding of the PRIMO Program to create new funding for deserving medical students' scholarships so that the underserved areas of Missouri can have an adequate number of physicians, particularly in rural Missouri, well into the next century.

Action: **Adopted** MoMed

The Nephrology Research Laboratory is seeking a highly motivated Research Assistant who works well in a unified group setting. This individual will carry out projects which will require a dedication to detail of technique as well as powers of critical observation and reporting. There will be general supervision from the principal investigator and the laboratory manager hence this individual will be expected to function at a professional level in terms of quality, quantity, and outcome of the projects assigned. A minimum of a Masters degree and two years experience working with rats in the academic research domain is desirable. Experience in a related area or an equivalent combination of education and experience from which comparable knowledge and ability can be acquired will also be acceptable. Please send CV and letter of application to Ramesh Khanna, MD, Division of Nephrology, Department of Internal Medicine, MA436 Medical Science Building, Columbia, MO 65212. The University of Missouri is an Affirmative Action/Equal Opportunity Employer and complies with the ADA act of 1990. Women and minorities are encouraged to apply.

Dr. Coble Praises MSMA Accomplishments

Mr. President, Mr. Past President, congratulations to you both for a superb tenure and a new regime.

It's a great honor, privilege and pleasure to be with you today. I am enthusiastic about it for several reasons. First, I have to issue this disclaimer. Anybody who's grown up for the first 25 years of their life in Burlington, North Carolina or within 25 miles, is enthusiastic about being anywhere.

I'll assure you that anybody who grows up in a small southern town with the name of Yank is just as enthusiastic about surviving.

But I was very enthusiastic, even before I got here, about what you've accomplished. What you've accomplished in tort reform is certainly the envy of Florida. And what you've accomplished in terms of patient rights and patient protections is certainly the envy of the AMA. If we could accomplish what you've done and set up such reforms as well, we would certainly go home very happy from Congress today.

I'm enthusiastic about this meeting and the wonderful setting. The accomplishments that you've been able to help pilot over the past years are the envy of many state associations.

And of course that includes your PAC, which has been leading around the country for such a long time, and includes membership. Something you or I would want in a lot of places and something that you've been working aggressively on.

I couldn't help but be enthusiastic about the opportunity of spending time with your delegation that's been so effective in the AMA House of Delegates, and to meet with your leadership and a lot of you yesterday afternoon and hear some of the very piercing and appropriate questions. I assure you I don't take any of your questions personally. I do take the invitation and the hospitality personally. I appreciate that very much.

I think your Delegates are here to listen. You've given me the opportunity to hear some things that are very important to take back.

I'm here to address just a few things that the AMA is doing. We addressed a lot of them yesterday. A few things need a little more attention. What are some of the key issues and why I think we should be more enthusiastic and optimistic about what's happening.

Dr. Yank Coble, a Florida endocrinologist and member of the AMA Board of Trustees, addresses the House of Delegates.

First, in terms of what the AMA is doing. We tend to forget that our mission is to promote the art and science of medicine as it's related to the public health. That's what the AMA has been doing for 150 years; we do it extraordinarily well, and it's the envy of the world.

The AMA has been a significant publisher of scientific material in the world. It publishes in 13 languages and in 17 countries. So it's a really rather unique involvement in scientific publications.

But it's also very involved in continuing medical education, as you know. There's no country in the world in which the professionalism is as high; we're so involved in the accreditation and standard-setting arena. Standard setting not only in the medical practice, but standard setting in the quality of care arena as well.

As you know, our Institute of Ethics has been a very successful, new innovation of recent years. The Ethic Program, like Care Program funded by the Robert Wood Johnson Foundation, has been extremely successful in training in terms of quality of care.

This is very difficult, not just because physicians are busy and perhaps haven't had as much training as we should, but because of the societal changes. People no longer have family systems, support systems, and their role in society has been pushed around, their kind of comfort zone that many people have in this difficult time in their life. And it's something the public is very much interested in. And we are fortunate to be able to take a leadership role in this arena.

Certainly, the Patient Safety Foundation, which was initiated by MSMA, introduced years ago, has been a significant success.

The American Medical Association Program is rather unique in its leadership of physicians providing some of the accountability and visibility in continuing our own self-enhancement. And preempting some of the regulatory agencies that want to reduce quality of care to a simple standard that they define, not you as a physician define. We are really the ones to make those determinations.

In other areas of standards, we've been particularly involved with JCHO as one of the corporate members. And there is a significant change in how that operation is functioning, particularly with the turnover in the leadership of some of the other corporate members.

That organization consumes a lot of the new attention from the other corporate members. The new executive at the College of Surgeons is now attending corporate meetings. And he too is very instrumental. But there is a significant turnover to JCHO's approach to some of the issues that we are particularly concerned about; issues such as restraints. There have been hearings around the country on the issue of restraints, which you know has become a very burdensome thing in terms of the amount of documentation. And yet on the other hand, there is a large amount of public concern and consumer advocacy regarding this.

We've been very aggressive about some other things that may not seem quite as important. One of them is plain old definitions.

Growing up in the middle of North Carolina, about the only folks who went to college were the doctor and the minister. And the person who was the health care provider were grandmothers. My grandmother was the best health care provider I've ever seen in my life. Remember mustard plaster? She'd use tobacco spit to fix a bee sting. She could make some sulphur molasses, a miracle that would cure you before you even took it.

She was an excellent health care provider. But she made no pretense whatsoever about being a health care professional. She had good judgment, she had your interest at heart. She wasn't making a big buck on it.

As you know, the alternative medicine industry is now a $50 billion a year out-of-pocket industry. That's big bucks.

So these health care providers are a very valuable part of the health care team. They make no pretensions with things. So we think it's very important that we don't accept the word provider for physician. I made that particular point at the National Guideline Clearinghouse, which has been in cooperation, amazingly enough, with the American Association of Health Plans, the American Medical Association, and the HCPR.

I would suggest that if anybody calls you a provider, that's like calling you some three-letter initials that were not good to be called when I grew up. You just say, "I don't accept that." This is an important link to the public. It doesn't give you the kind of indication and kind of position that you've got to have with your patient-physician relationship.

Now, of course, most visible and probably the most important to emphasize for you are the advocacy agenda that we have, both in the private sector and the public sector. We discussed a lot of that yesterday, the importance of having negotiating units or collective bargaining units, whatever you want to call it; advocating as aggressively as possible.

Of course, we do have to do it within antitrust restraints. We certainly must aggressively pursue advocates that can advise us in getting appropriate antitrust relief, not just for the physicians; relief for patients more than for physicians. We have to make sure that we make that clear. Advocacy is one of those very complex issues.

There's a list of priorities that we had passed out to you or sent to you. We won't go through it right now, but it is the top priority: advocacy for our patients, our profession, and our AMA.

The key issues, of course, always are membership and unity and solving our own problems. Certainly physician membership is critically important. We have a new membership committee, a new membership chair, and staff, that I think is much more sophisticated in communication.

As you've found out here, these peripheral things we offer aren't all that effective. A lot of the publication efforts aren't that effective. The most important thing, the most effective thing is you and me, one on one, telling our colleagues how important it is for membership.

Most of us belong to one, two, five or ten specialty societies. And that's wonderful. It is a great asset to our diversity. And we should praise that diversity, for there is strength in our unity and there is great danger in discord.

We are fortunate that two major specialty societies, at least in terms of size, have become much better, more cooperative partners in every activity that the AMA is involved in. I want to really applaud the American College of Physicians and the American Academy of Family Practice. And actually the other ones that are almost as large also are renewing their communications with their top staff and their top leadership. I think that's a very good, encouraging sign.

The solving of our own problems is critical. It reminds me of a line from several centuries ago on another continent: We have to evolve problem solvers alone because each problem government solves creates ten problems more.

I haven't seen any legislation, even those that we most carefully look at, that our legal colleagues can't find a way to make more confusing. This antitrust business, as you'll hear in the House of Delegates specialty reference committee in June, it is extraordinarily complex.

As we've all seen, the regulators in HCFA have certainly changed the game plan and the definition of what constitutes fraud and abuse; and then have elicited some of our major consumer advocate organizations to help them, as they did with the AARP recently. So we really must be investigating the system and be involved in solving our own problems and not counting on anybody solving them for us.

It makes it clear if there's any single message I have, it's that we've got a major commitment to make for our patients and our profession.

It's a great privilege to serve as a physician, to serve as a trustee. And we're going to have to express that privilege with a commitment to hard work with enthusiasm and optimism. And as Oschler said, hard work is the open sesame to every portal. We're the people watchers that lit up the whole world. The touchdown in terms of base metals, your anatomy would be gold.

We all know that organized medicine is hard work. It's not an easy job. It's got to be done with a lot of enthusiasm and optimism. How could we not be enthusiastic and optimistic about a profession that has such enduring traditions as ours? The tradition of ethics that is essential to the trusting relationship, only with that can we provide proper care.

And the caring physician. As Oschler said, "Caring is the most important thing, so do it first. It's the caring physician who best provides hope and trust. Again, hope and trust are essential to that relationship."

It's also easy to be enthusiastic about a profession that has such organizations as the AMA and the Missouri State Medical Association, and the staff that run those organizations, the democracy that exists within the organizations.

It's easy to be enthusiastic, particularly if the quality of care you receive or families receive has been good.

I went to a university very close to may hometown in Burlington. And, as I said, growing up in my hometown, it was hard for me to believe it was comparable to the rest of the word, so I went off to New York for residency. And I found that the quality of care there really wasn't very much different from what was rendered back in my little town of Burlington.

Our medicine came from other traditions. And so through the National Centers of Health, I had the opportunity to work in Nigeria; lived in England for a while. I found that the quality of our care back in Burlington, not at Duke, back in Burlington, was far better for my family than I could get living in London. It was a remarkable revelation.

Now, the real revelations for the young folks is, that was before 1965. That was before we had Medicare. My family could get better care in Burlington that I could get for my wife and children in London.

So it is not required for government to solve the problems for us. Whereas Medicare has been a wonderful thing for many people – and I'm not saying we should do away with it, although we should certainly reform it.

We have to remember that American medicine has some unique values, values that are far beyond the cost. I think cost is something we should look at. We're very sensitive about cost.

Did you take a look at the bottled water which we were served last night? Would anybody like to estimate how much money we spend on bottled water in this country? Five billion dollars a year.

How much on candles? $4-1/2 billion a year. $7-1/2 billion a year on vodka. $15 billion a year on salty snacks. $50 billion a year on alternative medicine. Thirty to $40 billion a year on obesity, diets, diet programs, et cetera. Over $50 billion a year on golf. $30 billion a year on sport fishing. Over $100 billion a year on alcohol and alcohol-related products. Over $300 billion a year on recreation and entertainment.

It's hard to believe that too much money is being spent on science and medicine when you look at all the money we're spending on these other things.

We know we need to do it better. We need to be more cost-effective. We need to reduce the variations in care. We need to look at the numbers. There's no need to feel defensive about the amount of money that we're spending on medicine or to feel like money isn't there to provide efficient care. It's there. It's a matter of where we want to spend our dollars. We shouldn't be defensive about doing that.

And so I'm really very optimist about our profession because I think we've got a wonderful profession. We've got a profession that allows us to have that one thing that all of us desire, and that's the ability to be useful. As professionals, as physicians, we can always be useful.

I'm also optimistic because the family of medicine is very effective. Our Alliance is remarkable in what they've accomplished. Our spouses and our patients. And we are all together a family of medicine.

I'm very optimistic because our organizations are very resilient, living, responsive organizations that are capable of continuous renewal. Organizations are a lot like people. They are capable of continual renewal.

And finally, I believe a physician should want to hire himself. I think that our profession and our organizations epitomize that mission to hire itself.

It's been a great pleasure to be here with you and hear your messages, which I will certainly do my best to take back to the AMA board. Thank you for your efforts, your patience, your professional organization, particularly the extraordinary hospitality and arrangements your staff and your leadership and your delegation have made. Thank you. I will be delighted to address any questions that you may have. **MoMed**

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Reports Referred to Reference Committees

President's Report - see page 169
MSMA Alliance Report - see page 205

Report of the Secretary

The Missouri State Medical Association had 5,465 members as of the December 1998 audit. This was a net gain of 16 members from our membership of 5,449 on the December 1997 audit. Following is a breakdown according to classification.

Year	Student	Resident	Active	Honor	Total
1997	406	156	3,840	1,063	5,465
1998	586	137	3,696	1,092	5,511
	+89	+2	-88	+13	+16

Number of member deaths reported during 1998 totaled 62.

The Committee on Nominations, which is appointed by the President, from the House of Delegates, must submit nominations for the following offices:

President-Elect to fill the unexpired term of William Dorzab, Raytown

Three Vice Presidents to fill the expired terms of Donald Fakhoury, Kansas City, Edward Plowman, Hannibal and Duane Hellam, Springfield

A Speaker and Vice Speaker to fill the expired terms of John Rollo, Speaker, St. Louis and Edwin Masters, Vice Speaker, Cape Girardeau. Both are eligible for re-election to their current position.

Three Delegates and Three Alternate Delegates to the AMA to fill the vacancies created by the expiration at the conclusion of the April 1999 Annual Convention of the terms of Robert T. Gibbons, Jr., Overland Park, Kansas; William Huffaker, St. Louis; H. Peter Ekern, Mexico and Alternate Delegates Gary Dyer, St. Joseph; James Wolfe, Springfield; Mr. Kamran Chaudhary, Kansas City. The new two year terms will begin at the conclusion of the 1999 MSMA Annual Convention and end at the conclusion of the 2001 MSMA Annual Convention.

The terms of the following Councilors will expire in 1999: 2nd District - Carl Kruse, Palmyra; 3rd District - Robert N. Miller, Arturo Montes, Meredith Payne and Gordon Goldman, St. Louis; 4th District - Sammy Farrell, Washington; 6th District - Jerry Meyer, Concordia; 7th District - Linda Dorzab, Raytown; 8th District - Clarence Martin, Joplin; 10th District - Thomas Sparkman, Cape Girardeau; Organized Medical Staff Section - Luis B. Anglo, St. Louis; Resident Physician Section - Jordan Page, Mission, KS; Medical Student Section - Mr. Tom Hulsen, Columbia. A Councilor is to be elected from the Young Physician Section with the term to begin in 1999 and expire in 2001.

The terms of the following Vice Councilors will expire in 1999: 2nd District - Lent Johnson, Hannibal; 4th District - Jeffrey Copeland, St. Peters; 6th District - Phillip Hornbostel, Sedalia; 8th District - Michael Hoeman, Springfield; 10th District - Kirby Turner, Poplar Bluff; Organized Medical Staff Section - Peggy Barjenbruch, Mexico; Resident Physician Section - Peter Peer, Kansas City; Medical Student Section Mr. Geoffrey Uy, St. Louis. A Vice Councilor is to be elected from the Young Physician Section with the term to begin in 1999 and expire in 2001.

Delegates shall meet during the Annual Convention prior to the last day and elect the Councilors and Vice Councilors for their respective districts and sections. The election shall be certified to the House of Delegates on the prescribed form which will be furnished.

The entire session will be held at the Tan-Tar-A Resort, Osage Beach, Missouri. The House of Delegates will hold its First Session on Thursday, April 8, 10:00 am, Salon B, the Second Session is on Friday, April 9, 4:00 pm, Salon B, and the Final Session will convene at 7:30 am, Sunday, April 11 in Salon A.

Registration facilities will be open on Thursday, and Friday from 7:00 am to 4:00 pm and Saturday from 7:00 to 2:00 pm. Registration will be in the Hotel Foyer.

James Wolfe, MD

Report of the Treasurer

The report of the Treasurer is covered in the Financial Statement which is published in the March issue of *Missouri Medicine* and appears in the Delegate's Handbook.

Edmond Cabbabe

Report of the Executive Vice President

Members of the Missouri State Medical Association can be proud of the advocacy they and their Association presented for their patients and their profession the past year.

Following on the heels of 1997, when the MSMA was primarily responsible for the passage of what is considered the nation's most extensive managed care regulatory bill (HB 335), Association members again supported their employed lobbying staff to push for adoption of legislation that (1) requires third party payers to reimburse for clean claims within 45 days or pay interest, (2) increased state payments for physicians participating in the Medicaid program by more than $10 million, and (3) continued to strengthen the state's anti-smoking and driving while drinking statutes.

In addition, members were responsible for the defeat of bills which would have greatly expanded the state's medical malpractice statute-of-limitations and several bills that could have exposed the public to unqualified health care through the expansion of the scope of practice of many limited licensed health providers.

Again during the present session of the Missouri Legislature many limited licensed professionals are attempting to expand their practices into the area of medicine through legislative efforts rather than through a medical education. Obviously, we need the active support of MSMA members again! I hope you will read the weekly Legislative Report members receive and relay your important opinions to your Legislators.

Representation Before the Bureaucrats: One of the lesser known, but very important, activities your Association carries out is to represent private medicine before both state and national bureaucracies. Government agencies draw up the regulations to implement the various legislation that is passed by the Legislature or Congress. Many times, these proposed regulations do not correspond with your Association's opinions on how the laws should be implemented. Frankly, the MSMA is probably the most successful organization in the state in having objectionable proposed regulations either withdrawn or rewritten in an acceptable manner.

Finances: Although the MSMA has the second lowest dues of any state medical association and has not increased dues since 1987, your Budget Committee believes our financial condition is sound enough to avoid a dues increase again this year and for the foreseeable future. This is primarily due to decreases in expenses and an increase in non-dues income. For additional information, please review the financial statements which are referred to Reference Committee B.

Special Activities: Along with the usual important duties the Association performs annually for the profession, each year presents new challenges that can arise quickly and demand resolution. The past several months saw your MSMA actively involved in several situations where members requested assistance in dealing with hospitals and insurers and even entered lawsuits challenging hospital attempts to lessen the importance of medial staff bylaws. You can expect continuing efforts on behalf of physicians in these key areas of concern.

The Association also took the lead in challenging the authority of a managed care entity to establish a mandatory hospitalist program. Following our challenge, the program was changed to voluntary. This issue will require constant review by members and the Association.

Publications: Response from members have shown that the Association publications are increasing their impact and readership due to emphasis on issues that are of direct concern to physicians. We invite your comments on how to improve communications with members.

Meetings: Your Association has continued to increase communications with other groups and has met on several occasions with the Board of Healing Arts, Department of Insurance, Department of Social Services (Medicaid), Missouri Managed Health Care Association, Missouri Association of Osteopathic Physicians and Surgeons, Missouri Hospital Association, Medical Group Managers Association, The Missouri Bar, and Missouri Association of Local Public Health Agencies. President Stephen Vilmer, MD, has traveled across the state visiting component medical societies.

Membership: Please review the list of nonmembers from your area at the MSMA booth in the

Exhibit Area. Your efforts and participation have made the MSMA the preeminent medical organization in our state. Our efforts in the Legislature and with the bureaucracy are highly respected by friends and foes alike. The services and assistance we offer our members and the public are many. This is an organization that members can look to with pride.

However, we must increase membership if the Association is to maintain its strength. Remember, nonmembers owe you a debt of gratitude for protecting their rights as physicians. It's time you told them to start paying their rightful share.

Leadership: I would like to thank all of the MSMA Officers and Councilors for giving freely of their time and efforts during many weekend meetings year after year. I especially appreciate the dedication of Drs. Stephen Vilmer, William Dorzab, and Gordon Goldman in dealing with the many problems that all leaders must tackle.

Staff: Carrying out the directives of this House of Delegates and the Council is the charge of your staff of 12. Those of you who have worked with or sought assistance from staff realize the dedication and expertise they provide to the medical community and to the public. We all owe each of them our sincere appreciation. Along with discharging the directives of the Association, we provide staffing for seven specialty societies, MMPAC, the Physicians Health Program, the Missouri State Medical Foundation and the Missouri State Medical Services. As you enjoy this Annual Convention, take a moment and visit with staff. It will be of benefit to both. Thank you for the privilege of serving!

C.C. "Cork" Swarens

Summary of 1998-1999 Council Minutes

Meeting of April 19, 1998, St. Louis

Stephen Vilmer, MD, President, presided. Gordon Goldman, MD, St. Louis, was elected Chair, and Norman P. Knowlton III, MD, Springfield, was elected Vice Chair. James Wolfe, MD, Springfield, was elected Secretary. Edmond Cabbabe, MD, St. Louis, was re-elected as Treasurer.

Meeting of June 6, 1998, Lake of the Ozarks

The MSMA Council voted to continue to support the efforts by the medical staff of St. John's Mercy Medical Center in St. Louis to amend their medical staff bylaws. The Council also reviewed suggested enhancements for the MSMA Annual Convention.

The Council adopted as MSMA policy that health delivery or financing systems which grant privileges to limited license health care practitioners should consider the "education, training, experience and demonstrated current competence and apply reasonable and nondiscriminatory standards" when granting similar privileges to licensed physicians, and that MSMA make all reasonable efforts, to see these policies enforced in health delivery or financing systems operating in Missouri.

The Council endorsed the efforts of the University of Missouri-Columbia Medical School Department of Family and Community Medicine's efforts to become a Family Practice Research Center and approved the submission of a late resolution to the AMA House of Delegates asking the AMA to address the Year 2000 computer problems.

MSMA also endorsed proposals from a) the Missouri Patient Care Review Foundation for a project for physician practices to increase detection and slow progression of diabetic kidney disease in Missouri Medicare patients and b) a project from the Missouri Department of Health to seek a CDC grant to develop a statewide Diabetes Control Program.

The following physicians were appointed to the Committee on Contract Negotiations:

Drs. William Dorzab, Chair; Octavio Chirino, Thomas Sparkman, Robert Wankum, and James Wolfe.

The following physicians were appointed to serve as Councilor Advisors as indicated: Commission on Continuing Education and Health Manpower - Arturo Montes, MD; Commission on Interspecialty Medicine - Carl Kruse, MD; Commission on Medical Economics, Third Party Medicine and Governmental Relations - Robert Miller, MD; Commission on Medical-Legal Affairs - Thomas Sparkman, MD; Commission on Public Affairs - David Barbe, MD; and Physicians Health Committee - Edmond Cabbabe, MD.

MSMA nominated Drs. Linda Dorzab and Meredith Payne to the AMA Women Physicians Congress and accepted the reports of the Commission on Public Affairs, Physicians Health Committee, Report of the Treasurer, Committee on Legislative Affairs, Executive Vice President, MSMA Alliance, MSMA Councilors, and the AMA. The minutes of the April 18, 1998, Council Meeting were approved and Council agreed to investigate the possibility of a different Council meeting site next June.

Meeting of August 23, 1998, Jefferson City

The Council approved a letter of intent to submit an amicus curiae in an appeal to the Missouri Supreme Court regarding hospital medical staff bylaws and reviewed a recent court case for MSMA to request the assistance of the AMA/State Association Litigation Center.

Council recommended that the current MOMEDICO agreement that is due to expire in 1999 be continued, if this is agreeable with MOMEDICO. MSMA also voted to support the Missouri Public Health Association in an application for a Robert Wood Johnson grant for education of physicians and the public on family violence and Hepatitis C.

MSMA supported the AMA in opposition to the "Lethal Drug Abuse Prevention Act of 1998" and the effort of Jordan Page, DO, to become the resident member on the AMPAC Board.

MSMA held meetings with the Medical Group Management Association; the Missouri Hospital Association and MAOPS; and with Ms. Sarah Grim, the new CEO of the Missouri Patient Care Review Foundation. MSMA recently hosted a meeting of component medical society executives.

The Council reviewed correspondence from the AMA regarding joint membership recruitment efforts. Information on members' medical savings accounts was disseminated and MSMA announced that it began to accept credit card payments for membership dues and other Association purchases.

MSMA met with other members of the Committee to Preserve Health Care to discuss possible tort reform legislation for the 1999 General Assembly.

The Council approved the Commission on Public Affairs report which called for conducting a media training seminar on January 23, 1999; developing a patient brochure on "How to Manage Your Managed Care Plan;" and building a resource database on public health topics.

The Council approved increasing the per diem for AMA Delegates and Alternates to $300 beginning in 1999. Several options were discussed to respond to MSMA Resolution #20 (A-98) which called for a committee to study the possibility of providing support to MSMA members in bargaining with health care systems over contracts.

The Committee on Membership and Governance reviewed current MSMA programs and requested staff to research the following projects for possible acceptance as MSMA membership programs: an ombudsman program to communicate with third party payors – a program currently exists and the Committee would like to explore the expansion of this program; possible dues discount programs to attract membership; district caucuses for fair representation; and patients' rights promotions where patients would be better informed about their rights under Missouri laws.

The Council appointed the following to serve on the Committee on Arrangements for the 1999 Annual Convention: Drs. Norman P. Knowlton, III, Springfield; Jerry Meyer, Concordia; and Robert Wankum, Jefferson City. The Council recommended that Drs. Arturo Montes, Florissant, and James Rogers, Springfield, be reappointed to three-year terms on the Missouri Patient Care Review Foundation Board.

The Committee on Continuing Medical Education reported on accreditation for the following: Missouri Baptist Medical Center, St. Louis - four years with commendation; Boone Hospital Center, Columbia - three years; Buchanan County Medical Society, St. Joseph - two years; Children's Mercy Hospital, Kansas City - four years; Community Hospital, Fairfax - two years; John Fitzgibbon Memorial Hospital, Marshall - three years; Freeman Health System, Joplin - four years with commendation; Greene County Medical Society, Springfield - four years; Liberty Hospital, Liberty - four years; and Medicus, Kansas City- one year provisional.

The Council accepted the Report of the Physicians Health Committee and Missouri State Medical Services.

Meeting of November 15, 1998, Jefferson City

A $102,000 public information campaign designed to educate patients concerning the nuances of managed care was approved. A companion Ombudsman Program was approved whereby MSMA members and patients can contact the MSMA Headquarters for assistance and advocacy during appeals of denied claims, services or other concerns.

The two outreach programs were part of a $1.9 million annual budget approved for 1999 by the Council. Also included in the budget was a membership outreach program which will include town hall-type meetings of MSMA members and nonmembers to focus on the concerns and needs of Missouri physicians.

The Council also decided to approach the House of Delegates with proposals to increase Association membership through special dues incentives for both individuals and groups.

In other actions, the Council sent a letter of concern pointing out possible problems with the Blue Cross/Blue Shield of Kansas City proposal to require patients in their plans who enter the North Kansas City Hospital through the emergency room to receive ongoing in-hospital care from Plan "hospitalists" rather than from the patient's primary care physician.

The Council was also brought up-to-date on a lawsuit the Association is involved in as an amicus curiae challenging an earlier ruling that hospital staff bylaws do not represent a contract in dealings with physician members of the staff.

MSMA staff was directed to develop a list of attorneys with a proven record of success in negotiating employment contracts for physicians. This list will be made available to members. It was recommended the nomination of Nathaniel Murdock, MD, of St. Louis, for a slot on the Practicing Physicians Advisory Council of HCFA.

It was voted to accept the University of Health Sciences Medical Student Chapter as a new Association chapter. The Council adopted a resolution that called upon the insurance and managed care industry to provide coverage for treatment of patients whose injuries are self-inflicted in suicide attempts.

Meeting of January 24, 1999, Jefferson City

The Legislative Committee reported MSMA has reached a compromise with Missouri Association of Trial Attorneys in regard to the statute of limitations on the filing of malpractice cases and this will be presented to the General Assembly. MSMA is also part of a coalition that recommended to the Governor that money from the tobacco settlement be placed in a trust fund for the education of children and youth on the dangers of smoking. MSMA will be opposing all bills that will expand the scope of practice of various health practitioners and will oppose a bill that would exempt physicians over the age of 65 and who have been in practice over 40 years from the CME requirements for licensure.

The Council directed a letter to express concern over a grant received from the Aetna Foundation and several pharmaceutical companies that would fund a course on managed care concepts in the UMC medical school curriculum. The Council also voted to inform the State Board of Registration for the Healing Arts of MSMA opposition to recommendations by the Federation of State Medical Boards regarding licensure of medical students and residents. MSMA will also sign on as a sponsor of Governor Carnahan's "Missouri Millennium Promise" driving safety program.

The Executive Committee discussed the endorsement by MSMA of publications on Medicare and Medicaid published by the United Communications Group. The Council approved the endorsement of these publications after assuring liability immunity for the Association.

After discussing the information MSMA had received from the AMA regarding the dismissal of the editor of JAMA, the Council voted to send a letter of support to E. Ratcliffe Anderson, MD, AMA Executive Vice President, regarding the dismissal of the editor. MSMA has received a "Physicians Accessing the Internet" grant to conduct Internet workshops in the State. It was also indicated that the MSMA Ombudsman Program would be bolstered.

Regarding the 1999 MSMA Annual Convention, Council was reminded the deadline for submission of resolutions for inclusion in the handbook is February 22. Councilors were asked to submit names for the Nominating Committee to the MSMA Headquarters prior to March 10. It was indicated that a resolution on MSMA dues and the bylaws had been distributed which will be introduced at the 1999 Annual Convention. It was recommended that Dr. Edmond Cabbabe, St. Louis, and Dr. Jean Chapman, Cape Girardeau, be the 1999 recipients of MSMA's Citizenship and Community Service Awards. The Council also approved the following to receive 1999 Legislative Awards: Senator Morris Westfall, Halfway; Representative Craig Hosmer, Springfield; Representative Chuck Pryor, Versailles.

The Council approved the recommendation that Dr. Mark Aeder, Kansas City, be reappointed to the Board of the Missouri Patient Care Review Foundation. It was also approved that the following vote MSMA proxy for shares in Missouri State Medical Services: Drs. A.J. Campbell, Stephen Vilmer, William Dorzab, Gordon Goldman and Norman Knowlton and Mr. C.C. Swarens. Drs. Vilmer, Dorzab, Goldman, Ekern and Barbe will attend the AMA Leadership Conference March 20-23 in Phoenix.

It was announced to the Council that MSMA Vice President, Dr. Edward Plowman, of Hannibal, had recently passed away. Dr. Newton White, District Three Councilor, thanked the Council for the support and assistance he had received during his years on board.

Reports were heard from the Commissions on Interspecialty Medicine, Continuing Education and Health Manpower, Medical Economics, and Public Affairs. Other reports were given on behalf of the Alliance, the Physicians Health Committee, Membership and Governance Committee, and Contracting Committee. Minutes of the November 15, 1998, Council Meeting, were approved.

Committee on Publications

The ninety-fifth volume of *Missouri Medicine* contained 11 scientific articles which covered a wide range of topics. The journal contained several regular departments including: Perspectives, Health Care Finance, Practice Management, Medical-Legal, Public Health, Editor's Desk, and President's Page. The specialty quiz section continued in 1998 with Radiology, thanks to Roger A. Francis, MD, and Emergency Medicine, thanks to Mark T. Steele, MD.

The January issue of *Missouri Medicine* continued to provide members with important legislative information and MSMA's financial statements were featured in the March issue. The August issue, better known as the Membership Directory, continued to be very popular as requests to purchase the directory were frequently made.

The MSMA Annual Convention preliminary program continued to be incorporated into *Missouri Medicine*. Each month more information was added, providing our members up-to-date information concerning the Convention. The official program was printed in the April issue and the Convention summary appeared in June.

The Publication Committee and Editor, J. Regan Thomas, MD, appreciate the contributions of the members and others who have filled the pages of *Missouri Medicine* with interesting, enjoyable articles. The Committee also appreciates the Association's continued support of the Journal.

Committee on Publications: J. Regan Thomas, MD, Chair; Philip C. Anderson, MD; John S. Daniels, MD; John C. Hagan, III, MD; Donald G. Sessions, MD.

Commission on Public Affairs

Mission: The Commission on Public Affairs began the year by reviewing its mission and defining responsibilities, which are, according to the MSMA Constitution and Bylaws: *"Planning and executing programs designed to enhance the relationship between the public and the medical profession. The Commission shall have responsibility in the fields of industrial health, environmental health, medicine and religion, trauma, disaster medical care and national defense, and other public matters."*

Managed Care Reform Public Education Campaign: At the 1998 August Council Meeting, it was determined that the Commission on Public Affairs and the MSMA Committee on Governance and Membership would jointly support a public education campaign regarding the new health care laws in Missouri. MSMA agreed to fund $102,000 for the campaign, which includes a public education brochure, a six-month radio campaign featuring 7,856 thirty-second spots, 14 outdoor billboards placed around the state, radio talk shows featuring MSMA physicians, and MSMA's website distributing the information on managed care rights.

Media Relations Training Seminar: After a recommendation by the Commission, a media training seminar was held with overwhelming success at the January 23, 1999, MSMA Council Meeting, to train members of the Public Affairs Commission, AMA Delegates, and MSMA Executive Committee. Inclusion of the Public Affairs Commission expanded the staple of MSMA spokespersons statewide. This program enabled the MSMA to train spokespersons to focus on medical issues at the local and state level. Future media training may include a program at the 1999 MSMA Annual Convention and media training at component societies.

Grant Opportunities: The Commission voted to forward topics for a Robert Woods Johnson Foundation grant on public health opportunities. This grant money was originally intended for a public health educational component in Missouri medical schools. Topics forwarded for grant project included handgun safety, education on hemochromotosis, clean indoor/outdoor air, making the workplace smoke-free, education on Hepatitis C, and/or the value of tobacco cessation in managed care.

Health Resource Data Base: The Commission voted to gather information on public health topics and their resources and make the information available on MSMA's home page on the Internet for downloading by physicians. This is an on-going project.

Resolution Status: The Commission discussed two resolutions passed at the MSMA A-98. Resolution #2 - *Avoid use of the Term "Provider" in Reference to MDs and DOs.* Resolution #10 - *Duty to "Actively" Disclose Health Care Practitioner Qualifications/Licensure.*

Resolution 2 was adopted and forwarded to the AMA A-98 where it was reaffirmed as current policy. Resolution 10 was adopted and will be published in the MSMA Policy Manual and will be publicized through current MSMA publications.

Breast Cancer Brochure: Approximately 6,000 "A Woman's Choice-Alternatives in Breast Cancer Treatments" brochures have been distributed to physicians and medical offices throughout the state. The availability of the brochure has been published in *Progress Notes.* Distribution and ordering information is also made available through MSMA's Home Page on the Internet. Brochures were made available at the annual conventions of the Medical Group Managers Association-Missouri and the Missouri Society of Internal Medicine. They will be made available at the 1999 Annual Convention at Lake of the Ozarks.

HIV Brochure/Consent Form: Approximately 5,000 "For My Patients, Taking the HIV/AID Test" Brochures and Consent Forms have been distributed to physicians and medical offices. The availability of the brochure has been published in *Progress Notes.* Distribution and ordering information is also made available through MSMA's Home Page on the Internet. Brochures were made available at the annual conventions of the Medical Group Managers Association-Missouri and the Missouri Society of Internal Medicine. They will be made available at the 1999 Annual Convention at Lake of the Ozarks.

Faster Distribution of News and Public Service Announcements: MSMA has been utilizing Missouri Net and The Link. Missouri Net reaches 90% of the radio markets in Missouri with its news twice an hour. The Link is an electronic wire service sending news releases to radio, television, and newspapers via modem.

Media Enquires and Placements for 1998-99 include: St. Louis Post Dispatch, Medical Economics Magazine, MD News Magazine, Kansas City; AMA News; Kansas City Business Journal; St. Louis Business Journal; Mid-Missouri Business Journal; Southeast Missourian, Cape Girardeau; Carthage Press; Columbia Daily Tribune; Jefferson City Post-Tribune; Boonville Daily Press; Chillicothe Constitution Tribune; Columbia Missourian; Fulton Sun; Joplin Globe; Springfield News Leader; Mexico Ledger; Quincy Herald Whig; Rolla Daily News; St. Joseph News-Press; West Plains Daily Quill; Kirksville Daily News; Kansas City Star; KMBZ-AM, Kansas City; KDRO-AM, Sedalia; KWOS-AM, Jefferson City; KJCF-AM, Festus; KWPM-AM, West Plains; KTTS-AM, Springfield; KOKO-AM, Warrensburg; KSLQ-AM, Sullivan/Washington; KELE-AM/FM, Mountain Grove; KXEO-AM, Mexico; Sedalia Democrat; KSFT-AM, St. Joseph;

KTRS-AM - St. Louis; Missouri Net, Statewide; KWTO-AM, Springfield

Commission on Public Affairs: Jim Blaine, MD, Chair; Jennifer Ashby, MD; Ronnie Brownsworth, MD; Diane Brukardt, MD; Nancy Bunge, MD; Don Coonce, MD; William Kapp, MD; Warren Lovinger, Jr., MD; John Lyskowski, MD; Mary Mason, MD; Suzanne Miller, MD; K. Lynn Moritz, MD; Ann Peick, MD; Michael Szewczyk, MD; Michael Zylka, MD;

Missouri State Medical Foundation

The Foundation has loaned more than $5.5 million to Missouri medical students, with almost $300,000 loaned in 1998. The CPA has again issued an unqualified opinion from the audit of the 1998 financial statements.

In 1998, a new loan program charging 7.8% interest was introduced to make the Foundation loans more competitive with the non-federal loans available to medical school students. Under the previous loan program interest was accrued at 4% while in medical school and at 10% after graduation.

The current financial strength of the Foundation is due to the strong support received from the MSMA and the MSMA Alliance. MSMA members were assessed $10 a year until 1987, the Alliance has targeted the Foundation for contributions through Christmas fundraising efforts, donations in memory of deceased physicians, and bequests from deceased members.

MSMF Board of Trustees: Frederick W. Hahn, MD, President; Patrick B. Harr, MD, Vice President; Robert H. Tanner, MD, Secretary-Treasurer; Harold Lurie, MD; Robert Schaaf, MD; Christopher H. Jung, MD; Donald Fakhoury, MD; Jennifer Page, MD; David Wilkinson, MD.

Missouri State Medical Services

In 1996, MSMS recommended to MSMA not to establish an HMO and to instead create an MSO (management services organization). Until January of 1999 MSMS was attempting to launch an MSO. The MSO never became operational and at this time all ventures will be pursued directly through the MSMA.

Board of Directors: Daniel O'Sullivan, MD, President; David Wilkinson, MD, Vice President; Pat Mills, Secretary-Treasurer; William Dorzab, MD; Clarence Martin, MD; Jeffrey Copeland, MD; C.C. Swarens; Stephen Vilmer, MD, ex-officio member.

Committee on Continuing Medical Education

The Committee on Continuing Medical Education met on August 10, November 12,1998 and January 1999.

The Committee members reviewed and reaffirmed the MSMA Policy on the Standards for Commercial Support of Continuing Medical Education. This Policy will be communicated to all MSMA accredited sponsors and incorporated into the MSMA Policy and Procedure Manual.

The Committee members also adopted a Manual for MSMA Site Surveyors. This document is a loose-leaf manual in order to conveniently modify individual pages. This manual will be of great assistance to the site surveyors in determining organizational compliance with the Essentials and Standards.

In order to renew the accreditation as a sponsor for continuing medical education, the Accreditation Council for Continuing Medical Education (ACCME) reviewed MSMA in January 1998. The ACCME expressed concern that although the Committee on Continuing Medical Education is a subcommittee of the Commission on Continuing Education and Health Manpower, the Committee's actions are not reviewed or approved by this Commission.

Minutes of the Committee on Continuing Medical Education will, in the future, be reviewed and approved by the Commission on Continuing Education and Health Manpower.

The Committee members recommended the following organizations be recognized as sponsors for CME activities based upon their compliance with the Essentials and Standards for Continuing Medical Education: Barnes-Jewish Hospital, *St. Peters*; Bothwell Regional Medical Center, *Sedalia*; Boone Hospital Center, *Columbia*; Buchanan County Medical Society, *St. Joseph*; Children's Mercy Hospital, *Kansas City*; Community Hospital, *Fairfax*; Columbia Regional Hospital, *Columbia*;

John Fitzgibbon Memorial Hospital, *Marshall*; Freeman Health System, *Joplin*; Fulton State Hospital, *Fulton*; Golden Valley Memorial Hospital, *Hannibal*; Greene County Medical Society, *Springfield*; Heart of America Diabetes Research Foundation, *North Kansas City*; Liberty Hospital, *Liberty*; Lutheran Medical Center, *St. Louis*; Missouri Baptist Medical Center, *St. Louis*; St. John's Mercy Medical Center, *St. Louis*; St. Mary's Health Center, *St. Louis.*

We appreciate the participation of the following Committee members: David S. Martin, MD; J. Thomas Critchlow, MD; Robert Schaaf, MD; Richard Heimburger, MD; George X. Trimble, MD; Aly Mohsen, MD; Kim Carmichael, MD; Richard Hellman, MD; Orin Trentham, III, MD.

Missouri Physicians Health Committee

The Missouri Physicians Health Committee met on April 18, 1998.

The Missouri Physicians Health (MPH) Committee, Missouri Psychiatric Association (MPA) and the MSMA Alliance jointly sponsored a seminar entitled "*Medical Marriages*" in conjunction with the 1998 MSMA Annual Convention at the Marriott's Pavilion Hotel in St. Louis, Missouri. This session was videotaped and the videos are available by contacting the MPH Program Coordinator. Following this seminar, the MPH and the MPA jointly sponsored an additional education offering on *"Litigation Stress"*.

The MSMA Alliance founded the De Novo Program to support the spouses and families of Missouri physicians, not just those in the MPH Program, with difficulties of any kind. The Mission Statement for the De Novo Program is *"The De Novo Program affirms the value of the medical family. It provides the spouses and children of physicians the opportunity to understand and overcome the stresses inherent in the medical family."*

The Alliance has been most supportive of the groups established in Cape Girardeau, Columbia, Kansas City, Springfield and St. Louis. This support has provided a strong educational focus to promote prevention and future educational offerings.

To enhance the awareness of the De Novo Program, Kathleen Lucas, Committee member, published an article in *Missouri Medicine* entitled, "Spread the Word . . . De Novo Is Here." In addition, De Novo articles have been published in journals such as *St. Louis Metropolitan Medicine*, *St. Louis Business Journal* and Greene County Medical Society's *Bulletin.*

The Committee members discussed activities to generate contributions to the MPH Program. Again, letters were forwarded to CEOs and medical staff presidents of Missouri hospitals soliciting financial support. MPH staff and Committee members have conducted educational offerings to hospital medical staffs to ensure their continued support. The Committee members expressed their sincere appreciation to the institutions that generously supported the MPH Program.

The participant fees for 1999 have been increased from $100 to $110 per month to defray the costs incurred by MPH Program. It is anticipated that participant fees will represent approximately 50% of MPH Program's actual expenditure.

The Committee recognized the contributions of Donald McIntosh, MD, Regional Coordinator for the Kansas city area. His dedication, insight and compassion has greatly enhanced the level of service to participants and medical staffs in the Kansas City area. He is truly making a difference.

Throughout the year, the Committee members staffed participants that have not been compliant with the spirit and intent of the Program's Advocacy Agreement.

We appreciate the participation of the following Committee members: Thomas Anderson, MD, Chair; John Lyskowski, MD; Thomas Cochran, MD; Charles Sincox, MD; Michael Freeman, MD; Donald McIntosh, MD; K. Lynn Moritz, MD; Jo-Ellyn Ryall, MD.

Commission on Interspecialty Medicine

The Commission on Interspecialty Medicine met on July 14, 1998 and January 19, 1999.

The Commission members reviewed the following area of responsibility as set forth in the MSMA Constitution and Bylaws:

> To review organizational problems with respect to scientific programs, socioeconomic

> and legislative matters that affect particular specialties; in addition, the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. The Commission shall provide close liaison between the various specialty organizations and MSMA.

In order for MSMA to better support the statewide specialty organizations, Commission members made the following suggestions: 1) Provide guidelines to deal with managed care; 2) Continue to assist with legislative concerns; and 3) Aid in distribution of educational materials related to referral guidelines and clinical indicators for surgical techniques. Commission members were encouraged to forward additional suggestions to MSMA.

The Commission members discussed the ongoing activities of the MSMA and the AMA to secure passage of a national managed reform package similar to the legislation enacted in Missouri last year. Members also discussed how their respective specialty organizations can support the Patients' Bill of Rights legislation, HR 3605 and S 1890, in Washington, D.C. Specialty representatives were asked to contact their members of Congress and urge them to support this legislation. Background packets were mailed to each Commission member.

The Commission members discussed plans for the 1999 MSMA Annual Convention, April 8-11 at Marriott's Tan-Tar-A Resort in Osage Beach, Missouri. In order to increase publicity to non MSMA members regarding the specialty programs and the general sessions, specialty organizations were asked to forward their mailing lists to MSMA.

We appreciate the participation of the following Commission members: Susan Berdy, MD, Allergy; Jeffrey Matson, MD, Anesthesiology; George Hruza, MD, Dermatology; Michael Szewczyk, MD, Emergency Physicians; Mark Martin, MD, Family Physicians; Warren Lovinger, MD, Internal Medicine; Martin Wice, MD, Physical Medicine and Rehabilitation; Gregory Tobin, MD, Plastic and Reconstructive Surgery; Joseph Hanaway, MD, Neurology; David Jimenez, MD, Neurosurgery; Marcus McCorcle, MD, Obstetrics and Gynecology; Michael Korenfeld, MD, Ophthalmology; Douglas Kiburz, MD, Orthopaedic Surgery; George Kletzker, MD, Otolaryngology; Russell Fiorella, MD, Pathology; Bernard Griesemer, MD, Pediatrics; Thomas Anderson, MD, Psychiatry; Ken Rall, MD, Radiology; Ann Peick, MD, Surgery; Michael Bukstein, MD, Surgery; Dennis Pyszczynski, MD, Thoracic; Michael Chehval, MD, Urology.

Commission on Continuing Education and Health Manpower

The Commission on Continuing Education and Health Manpower met on August 10, October 26, November 12, 1998.

The Commission members reviewed the following resolution referred by the MSMA Council:

Amended Resolution #12, *Lowering of Financial Barriers to the Education for Physicians at Schools of Medicine at the University of Missouri-Kansas City and the University of Missouri-Columbia.*

RESOLVED, that the Missouri State Medical Association encourage the General Assembly of the State of Missouri to increase the funding for the schools of Medicine at the University of Missouri-Kansas City and the University of Missouri-Columbia, with the specific purpose of lowering tuition costs to the medical students at the schools.

Recommendation: That MSMA Council request the Deans of the University of Missouri-Kansas City and University of Missouri-Columbia to provide regular reports on the progress of obtaining additional funding to ensure a diverse group of physicians will be able to serve Missourians.

The Commission members established a subcommittee - Physicians Advisory Committee on the Internet. The Committee's objectives are: 1) To provide oversight and leadership to help MSMA achieve long-term objectives with its information system; 2) To seek out and evaluate new electronic communication concepts that may benefit the Association; and 3) To encourage the advancement of member physicians' computer knowledge and use. The Committee's specific area of responsibility is MSMA's internal and external electronic information and communication systems.

In reviewing the participant evaluations from the 1998 MSMA Annual Convention, Commission members noted that the learning objectives of the educational offerings were met and consistent with the CME Mission Statement of the Association. The CME Mission Statement was revised to more accurately reflect the target audience and the anticipated activities in the future.

In response to participants' needs expressed on the evaluation forms, the Commission members selected "Preserving the Physician/Patient Relationship in an Managed Care Environment" as a theme for the General Session during the 1999 MSMA Annual Convention. This relationship is a patient care issue since a good relationship is correlated with a better patient outcome.

The Commission members reviewed and approved proposed changes for the MSMA Annual Convention scheduled for 2000. In addition to streamlining the Convention activities, these changes will enable MSMA to realize a cost savings.

MSMA has been awarded a grant from the Physicians Accessing the Internet (PAI) Project for 1999. The Association was awarded a similar grant in 1997. The PAI monies will fund educational activities in Springfield, Cape Girardeau, St. Louis, Kansas City, Joplin and Columbia/Jefferson City. Two courses will be offered at each location – a basic course in the morning with the intermediate/ advanced course in the afternoon. Each session will have a maximum class size of 30, for a total of 60 participants in each location. Individual sessions will be four hours in length and participants will receive four hours of Category 1 credit.

We appreciate the participation of the following members: David S. Martin, MD, Chair; Robert Schaaf, MD; Orin Trentham, III, MD; David J. Auner, MD; Kim Carmichael, MD; J. Thomas Critchlow, MD; David Fleming, MD; David Glover, MD; Richard Heimburger, MD; Richard Hellman, MD; Aly Mohsen, MD; Stuart Munro, MD; George X. Trimble, MD. MoMed

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Physicians Honored for Community Service

Dr. Edmond Cabbabe and **Dr. Jean Chapman** received the Missouri State Medical Association's 1999 Citizenship and Community Service Award at MSMA's 141st Annual Convention. The award recognizes physicians who have the extraordinary gift to reach beyond the practice of medicine.

Drs. Edmond Cabbabe, St. Louis, and Jean Chapman, Cape Girardeau, were honored for giving of their time to reach beyond the practice of medicine.

As a plastic surgeon for nearly 20 years, **Dr. Edmond Cabbabe** has reconstructed all kinds of scars and disfigurements. What some people might call cosmetic surgery, Dr. Cabbabe calls healing the whole person. He uses his skills as a surgeon and volunteers some of his time to remove, to rebuild, and to rejuvenate those in need of his talents.

As every good leader should, when Dr. Cabbabe was President of the St. Louis Metropolitan Medical Society in 1995, he outlined one of his goals for his tenure – establishing a program called, "Stop the Violence Before It Starts." The campaign was aimed at curbing violence in the St. Louis Community – the goal was to raise public awareness of violence and to refer victims or those at risk, to special agencies and organizations for assistance. But these kinds of programs take money, so Dr. Cabbabe raised funds from hospital medical staffs and administrations to help support his program.

As a plastic surgeon, Dr. Cabbabe put his talents where they would work the best – removing gang-related tatoos from youths. The teenagers were referred to the program after they had been successfully rehabilitated by civic, charitable, and government agencies. Dr. Cabbabe knew those tatoos presented belonged to a person who no longer wanted to be a part of a gang. He considers the tatoos' removal an award for these youths for abandoning their past destructive life and starting a constructive and productive life. Initially, the laser company provided their equipment free of charge. To continue the program, in the last three years Dr. Cabbabe has been successful in raising money from many sources including hospitals, churches, and private donors to pay for the laser rentals.

It is believed Dr. Cabbabe's program is the only one in the country where the entire treatment – including physician's fees, laser rental, and follow up – are provided to the teenagers free-of-charge. He has treated about 50 youths and wants to expand the program. Because of his fund raising efforts, the program has not been a financial drain on any of its beneficiaries or medical societies.

His volunteer activities do not stop at tatoo removal. He has been involved in Palestine's "Children Relief Fund" for many years. This program brings needy Palestinian children to the U.S. for surgical care. Dr. Cabbabe has also volunteered his time to raise money for the National Arab-American Medical Association and its Foundation, of which he is Chairman of the Board of Trustees. This program provides medical equipment, books, journals, pharmaceuticals, infant formula, and public health information to needy Arab-Americans in the U.S. and to people in the Middle East. It also provides scholarships to Arab-American medical students in the U.S.

His support of the Arab-American Medical Association includes participation in numerous overseas trips, offering teaching and provision of care to patients.

Dr. Cabbabe has reached out to his medical community in other ways as well. He has participated in the "Caring Foundation for Children" since 1990. He participates regularly as a volunteer faculty member in teaching plastic surgery at St. Louis University, which includes offering plastic surgery residents hands-on experience on a variety of procedures not available at the University. He has also volunteered in St. Louis University's preceptorship program for the last 12 years.

Dr. Jean Chapman was honored with the Community Service and Citizenship Award on his 40th anniversary of being a member of the Missouri State Medical Association and the Cape Girardeau County Area Medical Society.

In 1946, Dr. Chapman began his higher education at his hometown college, Southeast Missouri State University, then known as Southeast Missouri State College. He received his master's degree in anatomy from the University of Missouri-Columbia and then pursued his medical degree from Washington University School of Medicine in 1953. He went on to continue his medical training in internal medicine at St. Louis City Hospital and Barnes Hospital and then served as a general medical officer in the U.S. Air Force.

Dr. Chapman returned from his medical education and military service to serve the citizens of his hometown, Cape Girardeau, where he has now remained for 40 years. He also returned with a drive to support the importance of organized medicine as a voice for the individual practicing physician.

Dr. Chapman worked hard early to establish a public health department for Cape Girardeau County – he was the Health Officer for that office for eight years. He has served as Chief of the Medical Staff at Southeast Missouri Hospital and has served for 22 years on its Board of Trustees. From 1959 to 1997 – 38 years – he practiced internal medicine, specializing in allergy, asthma, and immunology and he has taught the senior residents from Southern Illinois University School of Medicine at Carbondale each year in this field.

He has been instrumental in helping the Educational Committee of the American Academy of Family Physicians develop its core curriculum in allergy and immunology and has assisted in the development of community-based allergy and immunology programs in more than 62 residency programs throughout the country.

Dr. Chapman is Chair of the Pollen and Mold Committee of the American Academy of Allergy and Immunology which initiated a program that gathers daily pollen and spore counts by volunteer certified aerobiologists around the U.S. The counts are used by allergists to track the seasonal variations, and by chemical researchers investigating pharmacotherapy for seasonal allergies.

In 1990 Dr. Chapman created the "Ask Your Doctor" program, a weekly live call-in cable television show. Over its eight years, Dr. Chapman has hosted more than 375 shows and has educated the public by interviewing physicians in all major specialties. This show is so popular, that the Medical Society limits members to two appearances annually.

Within his specialty, he was a founding member, President, and Secretary of the Missouri State Allergy Association. He has served on the Board, holding multiple offices and has served as President of the American Association of Certified Allergists. Dr. Chapman has been very active in the Missouri Society of Internal Medicine and the Missouri Chapter of the American College of Physicians, serving on the Board and Council and multiple committees of these organizations. In March of 1995, Dr. Chapman was one of 22 physicians nationally who attained the level of Master within the American College of Physicians. As of August of last year, only 346 physicians hold the level of master. In 1998, he served as President of the American College of Allergy, Asthma, and Immunology which serves a membership of more than 4,000 physicians.

Now that Dr. Chapman is retired, he is serving as a volunteer Artist in Residence at the Southeast Missouri State University Art Department, sculpting in the same classroom in which he studied art with college students while he was in junior high. Dr. Chapman's painting, "Spring - Iris No. 12" is featured on the cover of this issue of *Missouri Medicine.* MoMed

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Alliance President Judy Corry's Address to the MSMA House of Delegates

Good Morning!

It is a pleasure to bring greetings to this House of Delegates from the Missouri State Medical Association Alliance.

The dictionary gives the definition of "alliance" as a "joining of interests and efforts." The word "joining" seems especially pertinent as we have participated in a joint luncheon and joint presidents' reception. The Alliance has enjoyed the support of the Association with Dr. Stephen Vilmer leading the way throughout the past year. We were delighted to have Dr. Vilmer attend our Fall Conference and board meeting at the Chateau on the Lake. We also appreciate the opportunity to be represented at the Council meetings of the Association. Such exchanges help each organization to understand the essence of the other and to work together. As a representative of the Alliance, I was invited by Dr. Vilmer to accompany him while visiting several county societies. This practice effectively demonstrated the partnership between the Association and the Alliance.

As spouses of Missouri physicians, we of all people, know how busy you are and how much you care about your patients and the health of your community. We can express through our projects and activities the concern that medical families have for the well-being of the public.

To mention a few examples:

Several counties have introduced the program, "Baby Think It Over." Utilizing a life-size baby doll with an internal computer chip, the "baby" cries at random intervals 24 hours a day. It records the length of time it is allowed to cry, or if it is abused. Middle and high school students are assigned the care of these dolls for two or three days. The dolls have replaced the practice of students carrying around an egg or a sack of flour, which seldom cause any inconvenience. The teen pregnancy rate has been reduced in part by this program in several Iowa communities where it has been studied.

All counties are working to expand health education in their communities by encouraging the public to make healthier choices for themselves and their families. This is done through schools, museums, poster campaigns and health fairs.

Almost every county Alliance in the state has in some way adopted a local shelter assisting families suffering from violence in their homes. This was in response to the SAVE A SHELTER Program that our own Sandra Mitchell began while she was the AMA Alliance President in 1996-97. The SAVE (Stop American's Violence Everywhere) Program, initiated by the AMA Alliance, will continue in the coming year with an emphasis on the school.

Again this year, the Association and the Alliance are sponsoring a joint luncheon at noon tomorrow, providing CME credit for physicians. Learning to identify, document and treat domestic violence will be addressed by Dr. Zita Surprenant from Kansas City. Board certified in both occupational and emergency medicine, she actively serves as an advisor for the organization, Physicians for a Violence Free Society. If you have not reserved your complimentary luncheon ticket, you are still welcome to join us in Salon A for the presentation at 12:30 p.m.

The area of Legislation is demanding more and more of our time and attention because of the increasing number of bills affecting the practice of your profession, as well as the health care your patients receive. Who is going to speak up for you? We urge you and your member spouses to utilize the information provided by the Association and the Alliance. Make your voice heard!

Mini-internships allowing legislators and community leaders to see first hand what takes place in the day of a physician, are quite successful in several counties. Our Alliance Day at the Legislature in February was attended by 40 enthusiastic Alliance members and several physician spouses who shared their concerns with their legislators at breakfast in the Capitol.

The Alliance has made progress in the area of Resident Physician/Medical Student Spouse membership. In St. Louis a 2nd annual Post-Match Day Pizza Party for the fourth year medical students was held at St. Louis University and Washington University. This has provided an excellent opportunity to introduce the existence of the Alliance and encourage them to participate wherever they may be next year. This is just a beginning as we attempt to help the student and resident spouses discover what the Alliance does to support the profession of medicine and why they and their physician spouses should belong to our organizations.

De Novo is a program for the spouses and families of doctors in the Missouri Physicians Health Program. Other states have expressed interest in Missouri's one-of-a-kind De Novo program. Awareness within Missouri is growing and has stimulated expanding support from county Alliances. This year De Novo has provided assistance to families in five geographical areas of the state. The committee has created an explanatory brochure. I encourage you to pick up one from either registration table. The cookbook to be used as a fund raiser will be ready for purchase next year.

The Alliance is vital to raising funds enhancing the education of the next generation of physicians. Donating to the AMA Foundation, previously known as AMA-ERF, is a means of ensuring the future of the Profession. We extend an earnest invitation to attend the Mystery Dinner Theater and Silent Auction tomorrow evening at 7:30 pm. You will still be able to attend several receptions held earlier. The Deans of our medical schools will receive checks totaling more than $53,000. The Missouri Beef Industry Council has generously underwritten the evening making the entire cost of your tickets tax-deductible. The tickets are available at the registration desk. Please join us.

On behalf of the MSMA Alliance, I bring best wishes to the Association for a successful and productive 141st Annual Convention. Thank you. **MoMed**

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Installation of Beverly Murrell 1999-2000 MSMA Alliance President

Following is the MSMA Alliance Presidential Inaugeral Address given by Beverly Murrell, April 10,1999, at the Tan-Tar-A Resort in Osage Beach, Missouri.

Good afternoon! I'm so glad to see you all on this Spring Day! I've lived in Missouri now for fourteen years, and this may be the most beautiful Spring I've ever seen! And that's why we are here. The TIME IS NOW to celebrate a new year, new leaders, and a Springtime filled with promise.

In northeastern New Mexico where I grew up, Spring flowers usually fell victim to frost, so let's not let that happen to us.

In New Mexico, "mañana" was a common reply to "Let's work on taxes" – "mañana." "Let's clean up the basement" – "mañana" or "You need to quit smoking" – "mañana."

The Spanish dictionary defines "mañana" as "morning," "morrow," or "tomorrow." But it also in reality can mean "later," "there's no hurry," or "I really don't feel like it." There definitely was – and still is – a "mañana" attitude in New Mexico.

To some extent there is a "mañana" attitude in Missouri, too, as if tomorrow will be soon enough.

As we all know tomorrow sometimes never comes. But when it does arrive, it is, miraculously, today. And so today, we put off the wretched chore yet again and again.

We know the drill – choose regular exercise, low fat diet, avoid alcohol, don't smoke, get enough sleep, and avoid unsafe sex.

We scurry about facing many options, knowing that NOW is the time for making healthy choices in our own daily lives, and in our community health projects.

We in the Alliance have been so successful in our health projects: "Baby, Think It Over" is going

Beverly Murrell was sworn in as the 1999-2000 MSMA Alliance President by Jean Wankum, AMA Alliance Field Director and Cole County Medical Alliance member. Other newly installed officers – Marry Ann Duff, Kathy Riscoe, Betsy Jelley and Rhonda Wade – look on.

strong in several areas of the state. Other health programs include shelters and fundraisers for victims of violence and creating health museum exhibits. Groundbreaking for the new Health Adventure Center in Columbia will be in July – and for those of you who don't know, this is to be a hands-on, interactive museum that will be an attraction statewide. It will emphasize health choices and will be a significant source of health education for the state's young people.

The most innovative program in Missouri is De Novo, a wonderful support group for families in the Missouri Physicians Health Program.

In the legislative arena, we are talking to our senators and representatives helping them to understand the issues affecting patient care. Our mini-internships allow the legislators to shadow physicians on the job.

These are all terrific endeavors and we may all pat ourselves on the back. But we can't rest on our laurels. There is a situation with membership: it has dwindled down to 800. Perhaps the mañana attitude has caused some of us to be a bit lackadaisical and not worry too much. Perhaps a sense of urgency is needed. Increasing members means so much more...

- it means more manpower for our projects...
- it means more support for medicine and communities and ourselves ...
- and it means more delegates to voice our views at national.

Perhaps we can remedy this situation by some simple actions; find a membership list and ask each active member to call ONE other member or a potential member and encourage her or him to participate in our meetings and programs. DO IT TODAY – not mañana.

As a flower bends toward the Spring sunshine, so should we to gather strength and hope for the future. I am looking forward to working with each one of you, and NOW is the Time.

We are a great organization, doing many good things. We support each other. We have the medical family in common. We need each other.

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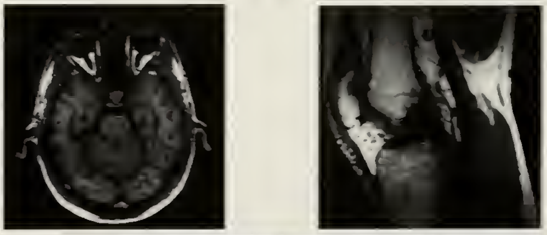

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Acute Interstitial Nephritis Following Amoxicillin Overdose

Sara F. Schellie, MD and Ted Groshong, MD

Abstract

Antibiotics are commonly prescribed medications for pediatric infections. Acute interstitial nephritis has been reported with B-lactam antibiotics.[1] We report the case of a 4-year-old boy who ingested 240mg/kg of amoxicillin and developed acute oliguric renal failure with hematuria and crystalluria. The patient was hospitalized for serial renal function and electrolyte evaluation. Although he developed hyperkalemia, full recovery was obtained with conservative management. This case emphasizes that medications considered to be non-toxic even with overdose can have serious adverse effects which may require therapeutic intervention.

Introduction

Amoxicillin is a broad spectrum semisynthetic penicillin commonly prescribed for pediatric infections because of its favorable pharmacokinetic properties and antimicrobial efficacy.[2,3,4,5,6] It is considered relatively non-toxic with therapeutic doses except for idiosyncratic hypersensitivity reactions.[6] Overdoses of amoxicillin in children have been associated with genitourinary, gastrointestinal and central nervous system symptoms.[3,4,5,6] Drug-induced acute interstitial nephritis is a relatively unappreciated adverse effect of amoxicillin toxicity.[6] We report the case of a 4-year-old boy who ingested 3.75g of amoxicillin and developed acute oliguric renal failure without associated allergic manifestations of eosinophilia, eosinophiluria, fever or skin rash. Although toxicity from amoxicillin ingestion is considered unlikely at doses less than 250mg/kg, this case discusses the serious adverse effects that can occur with smaller doses.

Case Report

A 4-year-old Caucasian male was prescribed generic amoxicillin 250mg/5mL (1 tsp tid) for an upper respiratory infection. Four days after initiation of treatment, he removed the amoxicillin suspension from the refrigerator and consumed approximately 75mL (3.750g or 240mg/kg). Approximately two hours later, he complained of difficulty passing urine, eventually passing a white crystal, followed by gross hematuria. He complained of abdominal pain, and had multiple episodes of spontaneous emesis. There was no history of NSAID use. He had no flank pain, increased urinary frequency, fever, edema or trauma. He was taken to Ozark Medical Center by his parents, and admitted for observation and monitoring of renal function and serum electrolytes. He was treated with intravenous hydration. He did not receive charcoal or any other means of decontamination.

On admission, blood pressure was 112/74mm Hg; temperature, 38.0°C; pulse, 105; respiration rate, 24 and weight, 16.5kg. He was asymptomatic. He had a normal urethral meatus. There was no abdominal guarding, rebound or organomegaly. There was no skin rash. The remainder of the physical examination was unremarkable.

Initially, BUN and creatinine were 13mg/dL and 0.7mg/dL, respectively. The urine appeared bloody and had a specific gravity of 1.015. Urinalysis revealed 4+ blood and 3+ protein and a pH of 8. Microscopy revealed 0-4 white blood cells per high power field, too numerous to count red blood cells, trace bacteria and large white clumps of crystals. The crystals were felt to be more reminiscent of sulfur based medications although crystalluria secondary to amoxicillin ingestion could not be ruled out.

By the third day of hospitalization, the urine was starting to clear although renal function was declining. The BUN had increased to 22mg/dL and the creatinine to 2.6mg/dL. The urine output was approximately 2mL/kg/hr and the patient was receiving intravenous fluids at the rate of 150%

maintenance. The patient was transferred to the University of Missouri Children's Hospital via ambulance.

Upon transfer he was noted to have periorbital edema. Blood pressure was 114/74mm Hg and temperature was 37.3°C. The erythrocyte sedimentation rate was 25mm/hr. The BUN was 21mg/dL and the creatinine peaked at 2.7mg/dL. Serum potassium was 4.8mmol/L. A urinalysis was within normal limits except for a large amount of blood. Urine potassium was 21.5mEq/L. A streptozyme titer was <1:100. Serum complement component C3 was 109mg/dL (reference range: 88-201mg/dL) and C4 was 21mg/dL (reference range: 16-47mg/dL). There was no eosinophilia. A renal ultrasound revealed an enlarged left kidney but no evidence of renal calculus, hydronephrosis, renal mass or perinephric fluid collection. The medullary portions of the kidneys were of normal echogenicity.

The patient was continued on maintenance intravenous fluids and blood pressure was checked every four hours. He was weighed twice daily. On day six of hospitalization, the BUN had reached 43mg/dL and the creatinine had declined to 1.4mg/dL. The potassium reached a peak of 6.4mmol/L and an EKG was obtained, which revealed a sinus arrhythmia with a rate of 68-104. There was no evidence of peaked T waves. Later that day, the potassium, BUN and creatinine were 5.5mmol/L, 44mg/dL and 1.2mg/dL, respectively. The patient was discharged to home with a follow-up appointment in two weeks, at which time he was noted to be clinically asymptomatic.

Discussion

Appel et al. have suggested three patterns of penicillin class drug-mediated renal injury. The most common form is acute tubulointerstitial nephritis. This is an idiosyncratic hypersensitivity reaction to the drug which becomes clinically evident after one to two weeks of drug therapy. It is manifested by hematuria, and occurs when large doses of the antibiotic are taken for extended periods. These patients may exhibit allergic manifestations such as eosinophilia, fever, rash and non-oliguric renal failure.[1] Systemic corticosteroids may be necessary for resolution.[5] A second type of penicillin class drug-mediated renal injury is focal acute glomerulonephritis and angiitis, that occurs after a single low dose of the drug. It is manifested by proteinuria, pyuria, hematuria and casts. The third form is anuric renal failure that occurs after a single dose in patients with underlying kidney disease.[1]

Amoxicillin-induced acute tubuointerstitial nephritis has been recognized in pediatric patients as a cause of acute renal failure.[1] Geller et al. first reported acute renal failure after amoxicillin overdose in 1986. Their patient was a 3-year-old male who presented with gross hematuria, lethargy, and vomiting after ingesting 7g of amoxicillin. He developed oliguria and his serum creatinine rose to 3.6mg/dL. There were no allergic manifestations and his condition improved in 72 hours with intravenous hydration.[5] Jones et al. reported two children with gross hematuria, vomiting and abdominal pain after consuming more than 6g of amoxicillin. Both children progressed to oliguric renal failure with serum creatinines of 2.6mg/dL and 2.1mg/dL. A renal ultrasound revealed large kidneys with increased echogenicity: one child was noted to have a large amount of debris in the left renal pelvis and bladder. A renal biopsy was performed on the patients and was described to be compatible with acute tubulointerstitial nephritis. The clinical symptoms resolved within 72 hours.[6] Belko et al. reported a patient who ingested 4g of amoxicillin and developed hematuria, dysuria, crystalluria and abdominal pain. The creatinine increased to 4.2mg/dL, although he never became oliguric. A renal ultrasound revealed moderately enlarged kidneys with increased echogenicity suggestive of intrinsic renal disease and the papillary structures were of irregular size and shape.[3]

The acute nature of the renal insufficiency in our patient following an overdose suggests acute tubulointerstitial nephritis. As observed in previously described patients, our patient presented with vomiting, oliguria, hematuria and crystalluria. The resolution of renal insufficiency was consistent with the previously described cases.[6]

According to Jones et al., potential mechanisms in the renal toxicity of large doses of amoxicillin include crystallization of the drug within the tubular lumen, renal venules or interstitium; direct cellular toxicity; vasoconstriction or an immediate hypersensitivity reaction. One hypothesis of the mechanism of acute renal failure following large doses of amoxicillin is mechanical tubular obstruction or vascular congestion. This results in acute renal failure and oliguria with the absence of significant renal tubular injury or death. Therefore, the kidney recovers fairly rapidly. Macroscopic hematuria after ingestion of a large dose of amoxicillin could potentially have been secondary to crystal-induced tubular injury. Penicillin-like drugs remain in the post-glomerular renal plasma and are excreted by movement from post-glomerular vessels through the interstitium, with transport across proximal renal tubular cells to reach the tubular lumen. It is plausible that the high plasma drug concentrations could have exceeded the secretory ability of the proximal tubule. Thus, conditions favoring drug crystallization and subsequent congestion of medullary vessels were present. This clinical entity could be similar to the medullary vascular congestion characteristic of sickle cell disease and sickle cell trait.[6]

Dilution is currently the mainstay of therapy for ingestions less than 350mg/kg. For ingestions greater than 350mg/kg, gastrointestinal decontamination with charcoal and admission for observation may be prudent if clinical signs are evident.[7]

Conclusion

Relatively safe drugs such as amoxicillin may have potentially serious side effects when taken in megadoses. This case emphasizes that adverse effects requiring observation and/or therapeutic intervention may develop with what traditionally has been considered a "benign overdose" of amoxicillin. MoMed

The Authors

Sara Schellie, MD, recently graduated from the University of Missouri-Columbia School of Medicine and is currently a pediatric resident at Pennsylvania State University, Hershey, PA. Ted Groshong, MD, is Interim Chair, Department of Child Health, and Interim Medical Director, Children's Hospital at the University Hospital and Clinics. The authors express appreciation to Rick Holloway, MD, West Plains, MO, for referral of this patient.

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Allen I. Herman, MD, 89, St. Joseph, died March 10, 1999. Dr. Herman practiced internal medicine and was a member of the Missouri State Medical Association.

John H. Mayer, Jr., MD, 83, Kansas City, died April 7, 1999. Dr. Mayer was a thoracic surgeon and a member of the Missouri State Medical Association.

Herbert H. Kaufmann, MD, 70, Mission Hills, KS, died April 14, 1999. Dr. Kaufmann was an obstetrician/gynecologist and a member of the Missouri State Medical Association.

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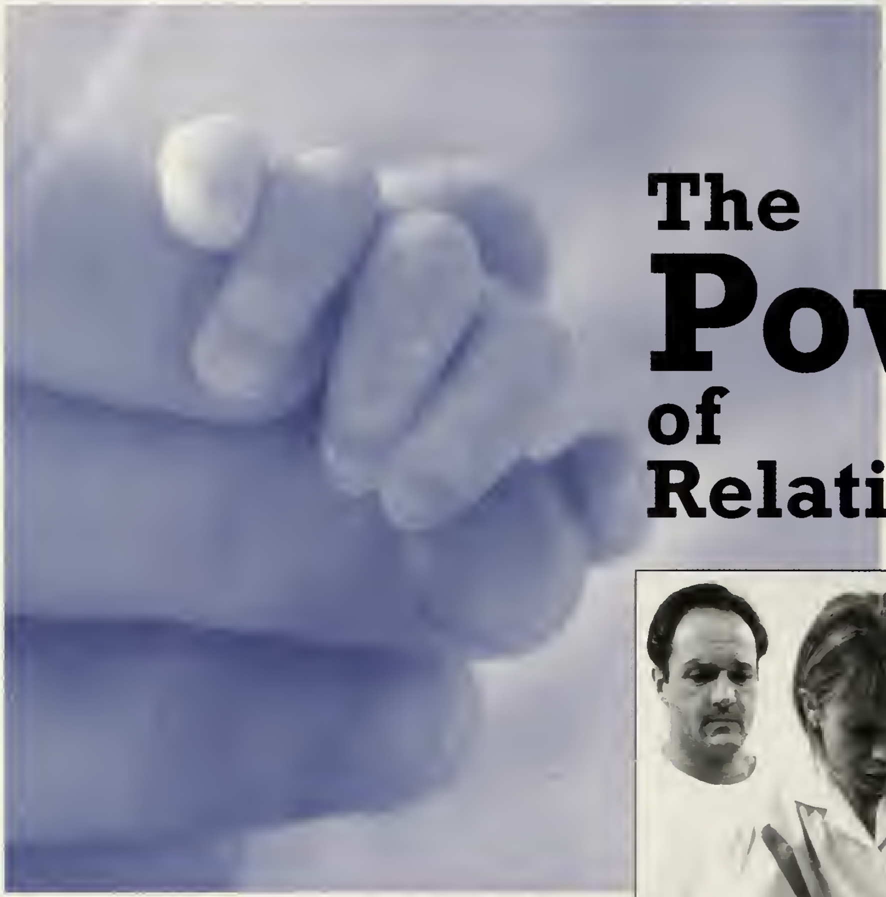

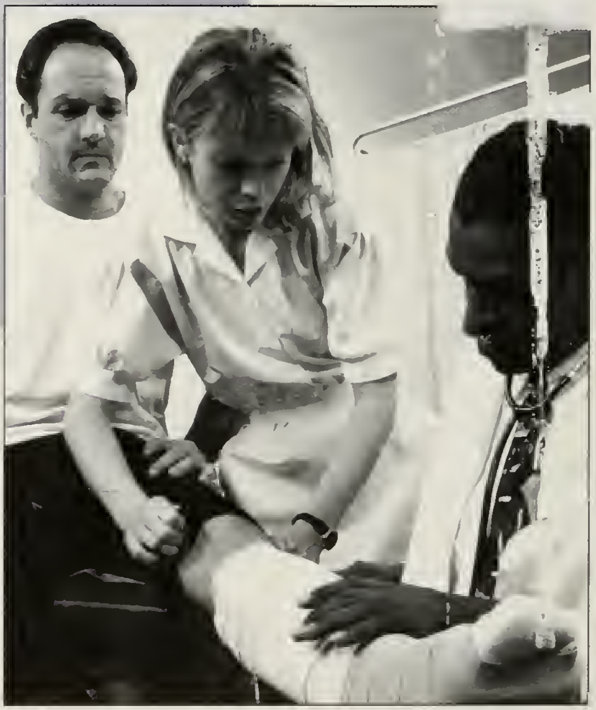

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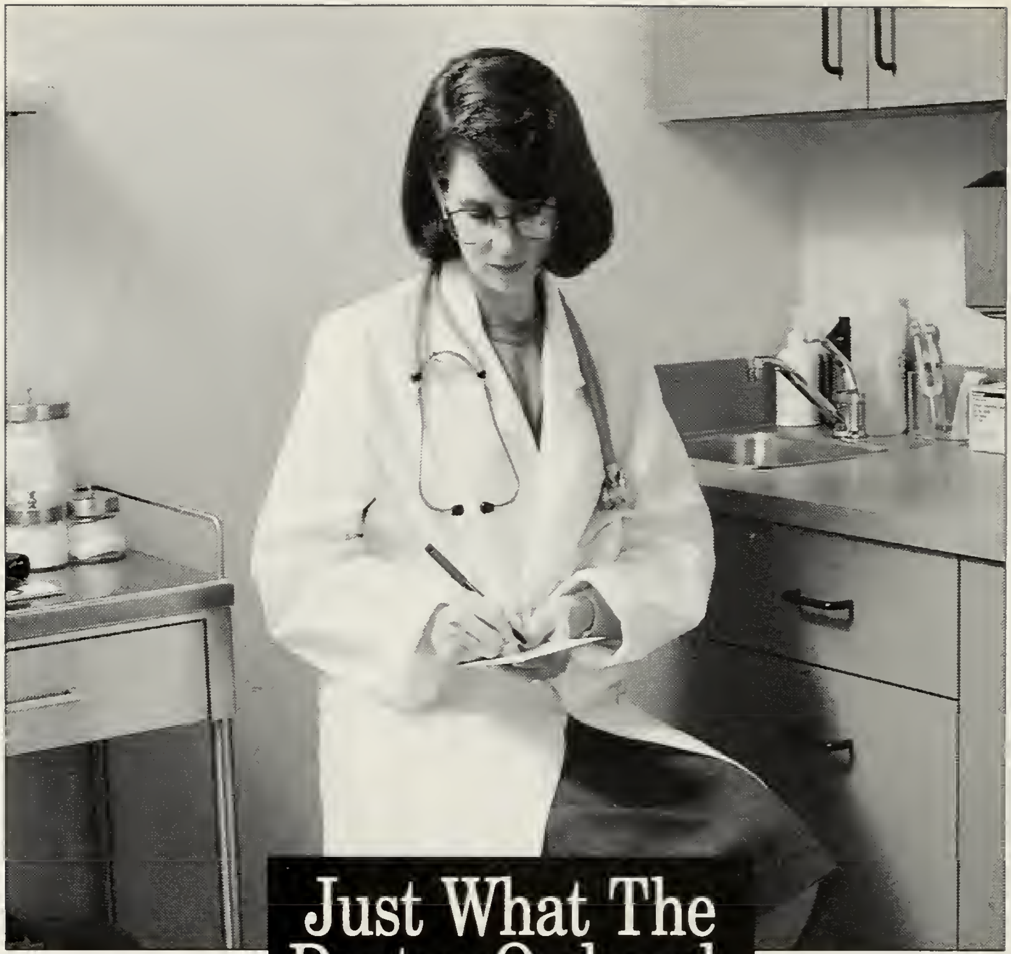
CORRECTION

The artist's name in the "On the Cover" information on page 167 of the June issue of *Missouri Medicine* was incorrect. The correct name of the artist is Jean Chapman, MD, from Cape Girardeau, Missouri.

On the Cover: "For His Future - Buy War Bonds" - by Lawrence Beall Smith. This oil on board was painted in 1942 and is 40" x 28¾". It is from the collection of Harry B. Cohen, MD, Columbia Missouri, who practices anesthesiology in Mexico, Missouri.



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A Fond Farewell

J. Regan Thomas, MD

This annual meeting of the AMA was my last as a delegate. After having the privilege of serving as the delegate for the American Academy of Facial Plastic and Reconstructive Surgery for 16 years it seemed like the right time to step down and give someone else the opportunity. I feel I have represented my constituents well for those 16 years and I have thoroughly enjoyed my interaction with the AMA and the House of Delegates. AMA participation has been a major component of my professional life and as I review those years some great memories come to mind.

In the early years, I had the distinction of being the youngest regular delegate in the House and the only one under 40 years of age. With the support of both the Missouri delegation and my specialty group, I was named to the ad hoc committee on the young physician. The work of that committee ultimately led to the formation of the Young Physician Section. Selection to the first governing board of the Young Physician Section was a tremendous honor and a gratifying experience after helping to create that important component of organized medicine.

Although I attended the House of Delegates as a specialty delegate, I genuinely enjoyed the close relationship and the state delegation activities that the Missouri delegation graciously provided. Along with all the great camaraderie and cooperative efforts through the years, several highlights come to mind. One of these was selection by the Missouri Delegation to present the nominating speech for Hugh Ritter's campaign for President of the AMA. Another privilege was the opportunity to be active in the campaign for Hugh Stephenson's election for the Council for Medical Education.

> Through participation at the MSMA, we can guide deliberations of our Missouri AMA delegation and in turn help impact American medicine.

Likewise, service on multiple reference committees for the House of Delegates through the years was not only interesting but also provided the chance to make some new friendships. Chairing a reference committee provided a unique challenge. Serving on the reference committee F, which dealt with the financial and fiscal governance of the AMA during an EVP transition period was particularly memorable and educational.

The AMA met in Honolulu three times during my tenure as a delegate. Twice the meeting coincided with the same week as the Honolulu marathon. Great personal memories include running the Honolulu marathon the first time with my wife, and this past year (10 years later) with my daughter.

Most of all, as I look back on these many AMA delegate years, I will remember my many good friends from the Missouri AMA delegation and the MSMA staff. I will miss the many "AMA friends" from all over the country I have enjoyed through the years. It was a true honor to work with all these dedicated physicians and professional staff members.

As a final part of this AMA farewell, I want to emphasize the importance of our membership in the AMA. No other group has a stronger or more credible voice for physicians. Few if any groups are as democratic in their deliberations or give more access and response to direction from the "grassroots" membership. Through participation at the MSMA, we can guide deliberations of our Missouri AMA delegation and in turn help impact American medicine. It is a terrific organization. I am delighted to move on from my position as delegate, but I will also miss being part of the process. MoMed

A New Era for Medical Schools: Maybe Teaching Medicine Isn't Enough?

As I progress through the clerkships of the clinical years of medical school, I am beginning to learn the basic principles of diagnosis and therapy which all physicians must understand. During the next several arduous but valuable years of my training, I hope to broaden and refine these clinical skills in the context of whichever specialty I choose to enter, a decision which looms larger every day. Ultimately, after persevering through countless early morning rounds, 3 a.m. pages, and what will likely soon became a caffeine addiction, I hope to gain the knowledge and clinical experience necessary to practice medicine independently.

However, the more exposure I have to clinical medicine, the more I realize it requires more than strong clinical skills and sincere compassion to practice medicine today. Unfortunately, medicine is not practiced in a Utopian world where physicians have unlimited time and health care resources to offer their patients. Physicians today must practice medicine within an extremely complicated and volatile health care system which increasingly demands productivity and efficiency. Regardless of individual opinions, economic and policy issues have enormous impact on our health care system and its continuing evolution. In addition to considering the best diagnostic tests or treatments for their patients, physicians today must be concerned with such economic issues including cost-effectiveness, reimbursement, and productivity. To remain successful in private practice, physicians must hone their managerial as well as their clinical skills. Whether we in the medical community like it or not, medicine has become more of a business than it used to be.

Traditionally, undergraduate and graduate medical education has provided very little, if any, training in health care economics, management, and policy. For a variety of reasons, medical schools and residency programs have traditionally left their graduates to learn about these matters for themselves as they finish their training and begin their professional careers. In the past, many medical educators considered issues of health care economics and policy to be beyond the scope of undergraduate and graduate medical education, or at least, of considerably less importance than scientific and clinical training. However, recently, due to widespread physician dissatisfaction with changes in our health care system and the growth of managed care, some medical educators have come to believe that teaching students and residents about economics and management conflicted with the fundamental goal of medical education; training competent, caring physicians who are unyielding advocates for their patients. There are those who believe that training in health economics would only "pollute" medical education with concepts that have become contradictory to the nature of being a physician. In short, the purpose of medical education has always been, (and to many, still should be) to produce doctors, not administrators or bureaucrats.

Given the complexity and the rapid change of our health care system, this approach to medical education is neither realistic nor beneficial. In fact, it may be detrimental. Training future physicians with little or no understanding of the economics and policies which will dramatically affect their careers puts them at great disadvantage because it leaves them without a realistic, pragmatic perspective of issues which will profoundly impact their day-to-day jobs. Today, the majority of medical students graduate with little formal knowledge of the basic structure and financing of traditional indemnity insurance, much less be able to navigate the complicated alphabet soup of managed care arrangements (i.e. IPA, PPO, POS...etc.). Further, while a graduating chief resident entering private practice may excel at treating his patients, he will likely have little knowledge of how to attract new patients, maintain organized records of their care, negotiate contracts with their insurers, or manage an efficient office that serves them best.

For this reason, I believe that both undergraduate and graduate medical education should incorporate training in health care management, economics, and policy into their curricula. Regardless of the specialty or type of practice they enter, I believe that all future physicians should have a basic understanding of health insurance, government-sponsored health programs (e.g. Medicare), and managed care. By basic understanding, I mean the structure of these institutions, their funding, their influence upon clinical practice, and especially, how they have (or have not) changed in recent years. In addition, because a significant proportion of medical students and residents will enter private practice, I believe that further education in small business management and administration would be extremely beneficial. After completing three years of medical school, I am convinced that the marginal benefit of such additional training in health care economics and policy would be considerably higher than additional study in anatomy or biochemistry, for example.

In addition to better preparing future physicians for their careers, I believe that education in health care economics would serve as a vehicle for physician empowerment within a rapidly changing health care system. In recent years, changes in our health care system have resulted in loss of physician autonomy, income, and ability to maintain strong therapeutic relationships with patients. I believe becoming knowledgeable about health care economics, would enable future physicians to become strong advocates for their professional autonomy, as well as for the rights of their patients. Further, with training in health economics and policy, future physicians would be better prepared to assume leadership roles in implementing policy and effecting change within our health care system, rather than passively allowing politicians, administrators, and lawyers to do so.

In short, the recent and dramatic changes in our health care system have augmented the knowledge and skills required to successfully practice medicine. In order for future physicians to become effective advocates for their patients as well as their profession as a whole, they require practical knowledge of health care economics and policy. Because it has the responsibility of training caring, competent physicians, medical education has the responsibility to cultivate this knowledge. Simply stated, as our health care system continues to change rapidly, medical education must evolve with it.

Micah R. Tepper
Fourth Year Medical Student
University of Missouri-Columbia School of Medicine

To the Editor . . .

I wanted to write a note to thank MSMA for arranging our recent seminar on "Physicians Accessing the Internet." We had a full house for both sessions, and I have heard nothing but good comments, both on the evaluation sheets and verbally since the meeting, about Dr. Worth, the content of the program and the fact that it was hands-on. Dr. Worth presented the information in an easy to understand manner, related well to the audience, and provided them with specific, useful training which will enhance their use of the Internet as a clinical resource.

Is there any possibility of arranging another session in the fall? I understand the seminar costs more than $1,000 for the day, but we do not have funding for that at this time. Does the arrangement between MSMA and the AMA permit another session? We have already had requests for another.

As usual, thanks for your help.

Sincerely,

Lois R. Hayes
Managing Director
Greene County Medical Society

Thank you very much for arranging the "Physicians Accessing the Internet" course that met April 24. It was very well done and most beneficial.

We should do more things like this.

My hat is off to Lois and all the hard work she puts in.

Best regards,

Richard H. Loeb, MD
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Getting the Message Out

William Dorzab, MD

How many times have we heard: "Organized medicine is ineffective. I'm thinking of dropping my memberships to the AMA and the MSMA?"

It is difficult for many of us to understand how physicians come to this conclusion. But they do. There must be a major breakdown in the lines of communication between our medical organizations and physicians.

To begin improving interaction between local physicians and organized medicine in Missouri, MSMA recently started Operation House Call. Presentations by our able staff (Lizabeth Starnes, Director of Communications, and Jay Harms, Director of Field Services) and officers of county medical societies and MSMA have fostered a landslide of effective interaction across Missouri.

Audience comments and insights at Operation House Call meetings were just as useful as the presentations, themselves.

Physicians from all areas of the state lauded the Legislative Report and our Journal, *Missouri Medicine*. They craved help with practical solutions to the thorny problems they face every day, such as managed care and employment contract review. They longed for efficient communications over the Internet, with the opportunity to respond and interact with e-mail and in chat rooms.

Many physicians appeared to understand the importance of maintaining a strong physician organization that can be the profession's voice in legislative and public arenas. Others needed more concrete value. For those there was a sense that MSMA must find programs and benefits that will "return" a members dues in the form of practice savings. Malpractice insurance premiums, office supplies and equipment, CME activities and contract review are promising areas where MSMA might help physicians recoup their dues costs.

The town hall format of the programs created a comfortable setting, conducive to the free exchange of ideas. That is something we have needed for a long time. Answers to medicine's problems will not be found exclusively at Council or committee meetings. There must be an admixture of the grassroots perspective if balanced solutions are to be found.

But what about our patients and the public at large? Many of you and your patients are now noticing the large public relations campaign on highway billboards and over radio airwaves across our state.

The Health Care Rights Education Campaign is an effort to carry awareness of the important legislative accomplishments of the past few years to the general public. Our patients must know their new rights, so they can demand to be treated fairly by health plans. This campaign encourages patients to talk with their MSMA doctor about the issues. Informational materials available from MSMA will help physicians respond to patients' questions.

Where will all this lead? Your Officers and Staff hope lines of communication between physicians and organized medicine will open wide and remain open so that MSMA will know how to respond to the ever changing needs and concerns of its membership.

We also hope patients will play a pivotal role in the constructive evolution of our health care system when they are informed consumers and in close contact with their most trusted confidant for medical matters, their personal physician.

For more information on the Health Care Rights Campaign, or to ask for brochures or information on billboard locations or radio program schedules, please call 573-636-5151. MoMed

Fences and Managed Care

Gary A. Dyer, MD

Twenty miles east of St. Joseph in DeKalb County, an Osage orange (Maclura pomifera) hedge row separates Al's 40 from the farm Newcomb Dyer purchased from the Hannibal and St. Joseph Railroad in the autumn of 1868. If one looks closely in the grass, a few stumps remain of a double row, about ten feet apart, of closely spaced hedge trees planted by the same Newcomb Dyer. Two generations participated in keeping this double row of hedge hacked to a uniform height of about four feet. The hedge thorns kept desired animals in, and others out. The lane between the hedges was wide enough for a wagon and team of horses or driving cattle separated from the herd.

At the beginning of my father's generation, a fencing machine was purchased and segments of the hedge were replaced with woven wire. My father told me of cutting the hedges in his youth and the scratches and bleeding from the thorns. As you might guess, when he was allowed to express an opinion, he voted for more woven wire. Manufactured barbed and woven wire, mounted on hedge posts, gradually completely replaced the fencing machine wire and the trimmed hedge, leaving only the stumps.

I spent many days in my teens (it seemed mostly on Saturdays) repairing those rather cobbled fences (a good hedge post fence will last three generations) put in place by my father and grandfather. Thorn scratches and punctures were replaced by those created by wire with two and four barbs. More pierced, I believe, was my brain. I often thought to myself, "Why am I here? My brain is withering and wasting. Will my life ever amount to anything?"

> Today, the fences of managed care are separating physician members of the medical profession from each other like livestock in the fields.

Today, the fences of managed care are separating physician members of the medical profession from each other like livestock in the fields. The thorns of various schemes divide generalists from specialists, salaried from self-employed, and in some areas, academic physicians from those who are not. Equally important, the thorny rules and requirements separate patients from physicians of their choice, restrict treatment, or create hassles in delivery of care or receiving payment. The image of individual physicians is diminished, the noble profession suffers, and our local, state, and national associations shrink. Young physicians think of themselves more as hourly employees filling slots rather than fulfilling professional callings. The thorns and barbs cause greater pain in smaller communities where most physicians are good friends.

And now, we as physicians spend our Saturdays mending the fences of managed care, licking our wounds, and wondering what will our professional brains, our professional lives, and our professional associations amount to? Surely, there must shortly come a time for patients and physicians to express their opinion and vote to tear down the fences of managed care, or at the very least, severely prune back the thorns and barbs. MoMed

Electronic Claims Filing, To Be Or Not To Be

Ann Finley, Electronic Claims Specialist

With the computer age comes changes that are met with resistance from many of us who don't understand these changes and how it will affect the everyday office routine. This article is intended to answer some of those questions and to help you know what to look for in your search for the right program for you and your staff. The time will come when insurance companies will require electronic claim filing. Many of you are aware that Medicare has already set the wheels in motion.

Why are insurance companies using the electronic system? To be overly simplistic – money. Seems as though "money" is the root of most decisions made in business. Let's look at the difference between filing electronically and filing on paper.

Paper Claims
Claim received in mailroom
Hand-delivered to data entry room
Data entered
Hand-delivered to edit department
If no errors on claim, goes to payor
If errors found, claim sent back to you
Up to 30% rejection rate

Electronic Claims
Claim received in clearinghouse
Claim goes directly to payor
<2% rejection rate

The cost to the insurance company for every piece of paper you send them is approximately $12. By cutting out the mailroom, the data entry room, and the edit department, the cost is reduced to about $2.

The benefits to you, as the provider are:

1. Errors in claims are found sooner.
2. Claims are not "lost in the mail." A transmittal report is sent telling you that the claims were received.
3. Reduced cost in forms, postage, and envelopes.
4. You are paid in about 14 days as opposed to 30-120 days.[1]

What does a clearinghouse do? A clearinghouse edits, formats and transmits the claims to the proper insurance companies, thus reducing errors and rejected claims.

How do I know which clearinghouse to use? There are many clearinghouses in the country. Most are regional, which means they are contracted with insurance companies in a particular area. These regional clearinghouses typically only reach about 50% of the payors at best, which means that the other 50% are dropped to paper. The three largest clearinghouses, which reach approximately 80% of payors, are: NEIC, MedeAmerica, and ET&T.

How much do clearinghouses charge? There are two components to their charges. The first is set-up fees. The charge can be anywhere from $100 to $1500 per physician per year. The second component is the charge per claim. This charge can be $0.35 to $1.50 per claim.

What kind of computer system and program do I need? The needs of your computer system are dependent upon the program purchased. There are hundreds of programs available. Some commercial insurance companies have a program available to you at no cost. However, you are only able to file that company's claims. Having several programs that operate on a different system can be costly as it is time-consuming and a source of confusion to your staff.

Where do I start? In your search for the system that is right for you, the following items should be considered:

1. Cost of computer system.
2. Cost of program.
3. Y2K compliance. If you have a DOS-based program, you **will** have to upgrade your program, and possibly your computer.
4. Cost of clearinghouse and number of payors they reach.
5. Cost of set-up, not only in real dollars, but also the time it takes your staff to learn the program.

6. Change in your daily office routine. Do you need to hire additional staff?
7. What is the cost of **not** filing electronically? The cost to you as the provider in real dollars is anywhere from $7-10 per claim.

Dealing with all these issues can be very time-consuming and costly. Outsourcing your claims processing may be beneficial, costing from $2.50-$3.50 per claim. There, again, are many individuals and small companies available. Questions you need to ask are:

1. Which clearinghouse is used?
2. Are they Y2K compliant?
3. How much are set-up fees, if any?
4. How do they charge?
   Flat monthly rate?
   Per claim - Is there a new charge if an error is made and it needs to be resubmitted?
   Is there a charge for the claim even if you don't get paid?
5. Do I need to sign a contract and for how long?

Hopefully, some of your questions have been answered. Electronic filing is the most cost-effective, efficient way to file. It's not a matter *if* insurance companies are going to mandate electronic filing; it's a matter of *when*. MoMed

The Author

Ann Finley owns MediLink Solutions in Strafford, Missouri. She has an extensive background in the medical field as an RN for 28 years, with management experience in the clinic and emergency room arena and as a licensed health and life insurance agent.

Reference:

1. The industry standard is 7-21 days, depending upon the type of claim.

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Radiology Quiz

Roger A. Francis, MD, FACR
Diagnostic Imaging Department
Nevada Regional Medical Center

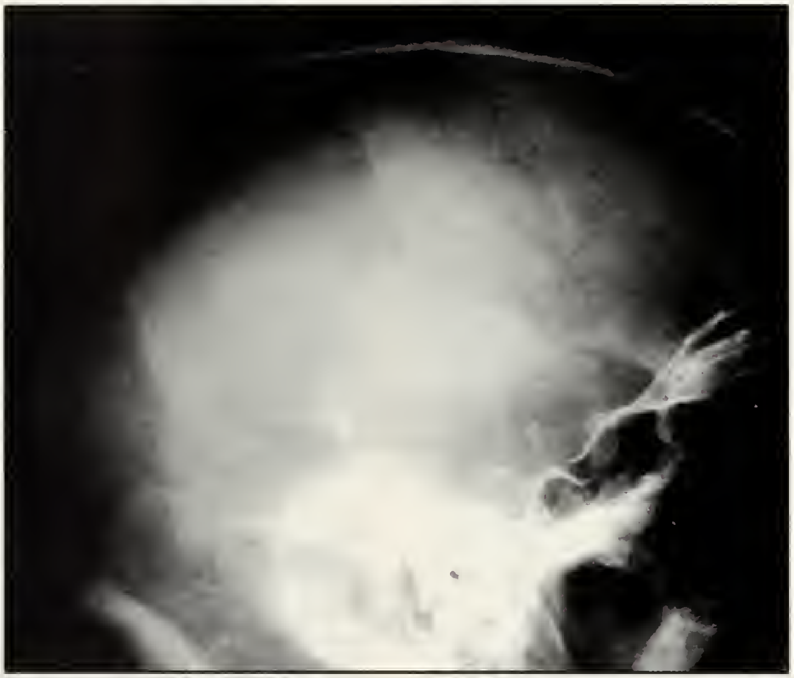

Figure 1

A 71-year-old male presented to clinic with new onset of headaches. Serum chemistries were normal except for marked elevation of alkaline phosphatase. As part of the workup, skull radiographs were obtained, with a lateral view submitted (Figure 1).

What is the most likely diagnosis

a. Multiple myeloma
b. Paget's disease of bone
c. Fibrous dysplasia
d. Osteoblastic metastases

(See answer on next page.)

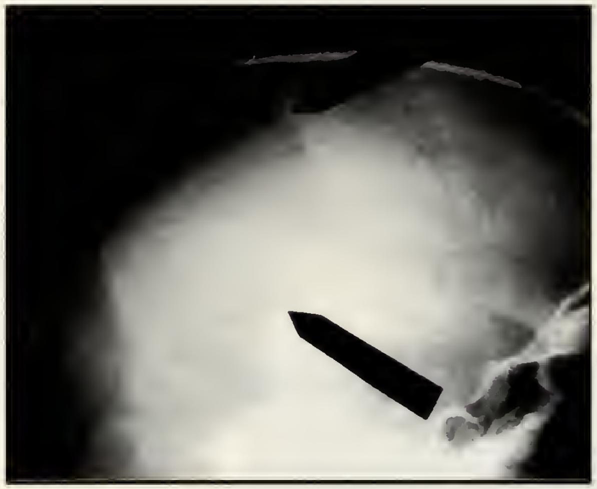

Figure 1 repeated

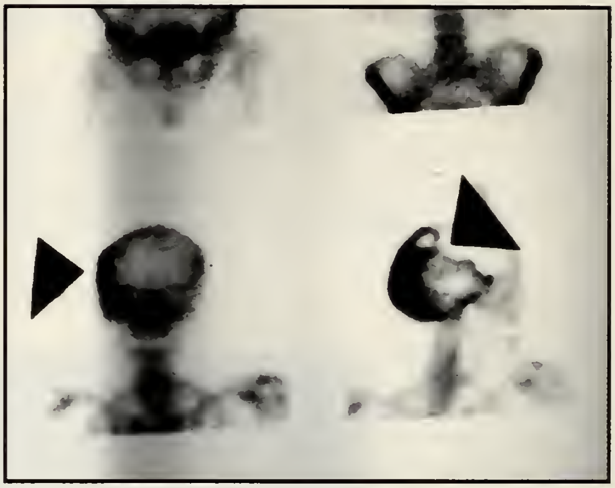

Figure 2

ANSWER

b - Paget's disease of bone

The lateral skull film shows a well defined, geographic zone of radiolucency (Figure 1 repeated) involving the right posterior skull. A 99mTc-HDP bone scan shows a zone of increased tracer uptake in the skull (Figure 2) corresponding to the lytic changes on the plain film. These changes, coupled with elevated serum alkaline phosphatase, are highly suggestive of Paget's disease of bone.

Paget's disease of bone is a disorder of bone remodeling which usually occurs in adults over 50. The early phase of the disorder is characterized by increased osteoclastic bony resorption, and is reflected radiographically by lytic destruction which is usually geographic. As the disease progresses, increased osteoblastic activity occurs, resulting in bony sclerosis and trabecular thickening. Bones affected most commonly are spine, skull, pelvis and femur. Involvement of long bones may result in bowing in advanced cases.

Patients usually are asymptomatic, but occasionally have symptoms such as bone pain or tenderness, bowing of long bones, or increasing hat size due to thickening of the calvarium. The only expected laboratory abnormality is marked elevation of the serum alkaline phosphatase, reflecting increased bone turnover. Complications of Paget's disease of bone may involve pathologic fracture or malignant degeneration of involved bone (Paget's sarcoma).

Plain radiographic findings vary depending on the degree of osteolytic or osteoblastic involvement. Osteolytic disease involving the skull is termed osteoporosis circumscripta, and shows a variable sized zone of bony lucency as in the test case. This may mimic lytic disease due to myeloma or osteolytic metastases, but these latter entities usually show multiple smaller lesions. The osteoblastic phase of the disease may mimic fibrous dysplasia or osteoblastic metastases.

Multiple myeloma would be unlikely to cause a single large, geographic lytic lesion as in the test case, and also would be unlikely to show increased uptake on the bone scan.

Fibrous dysplasia may cause thickening and sclerosis of skull bones and other bones, but would be unlikely to cause *lytic* skull lesions as shown in the test case.

Osteoblastic metastases, may mimic the bone forming phase of Paget's but would not be confused with the lytic appearance of the test case. **MoMed**

Reference

Taveras, J.M. & Ferrucci, J.T. *Radiology: Diagnosis- Imaging - Intervention.* Lippincott-Raven 1998, Vol. 5, Chpt. 63, pp 1-14.

A Career of Disease Prevention, Detection and Control: An Interview with Dr. Denny Donnell, State Epidemiologist of Missouri

Thomas Eppright, MD; Shane Bradley, CCRA;
Maureen A. Allwood, MS; James R. Slaughter, MD

Abstract

Denny Donnell began his tenure as Missouri State Epidemiologist in 1973. Since that time, he has been instrumental in the prevention, detection and control of disease across the state. In this interview he reflects on the path that led him to disease control and he emphasizes the need for further training opportunities for physicians who wish to battle disease beyond the realm of one person at a time.

Discussion

This interview was conducted as a tribute and celebration of Denny Donnell's contribution to the state of Missouri and to the medical community at-large. H. Denny Donnell, Jr., MD, MPH, has served as the State Epidemiologist of Missouri for more than 25 years. He grew up in Greenville, Illinois, where as a teenager he worked with his father who was a funeral director. He attended Greenville College for three years, then transferred to Washington University School of Medicine in St. Louis, from which he graduated in 1960. Dr. Donnell completed his undergraduate degree while in medical school and he married after his junior year. Denny and Martha Donnell have been married for 41 years and they are the proud parents and grandparents of three daughters and eight grandchildren.

***Question:* How did you develop an interest in public health?**

***Dr. Donnell*:** I completed my internship and a one-year assistant residency in surgery at Butterworth Hospital in Grand Rapids, Michigan. After the year of surgery I was drafted into the Army where I worked in preventive medicine. That time in the Army was very important in guiding my career toward public health. I actually explored public health during medical school. One of our lecturers at medical school was Dr. Herbert Domke, then the Director of the St. Louis County Health Department. He lectured on tuberculosis and other topics, several of us were interested enough to spend a summer working with him in the county health department. During that summer, I ran an IBM cards sorter, sorting data from a study about mental health attitudes. Besides the research, I was able to spend some time learning about well baby clinics, sewer systems, restaurant inspections, and what went on inside a metropolitan health department.

I still thought, however, that I would still be a surgeon. I was planning on becoming a medical missionary, and had been influenced by Dr. Albert Snyder, the senior resident in surgery at Butterworth Hospital, who was a Free Methodist missionary to Rwanda. Dr. Snyder had also graduated from Greenville College, and I had grown up a Free Methodist, so there was a strong connection there. But when the draft came and I went off to the military, I indicated that I had completed a year and a little more training in surgery and that I had some interest in preventive medicine. Well, the military had a great need at the time for physicians who specialized in preventive medicine, so I chose preventive medicine.

Dr. Phillip Winter, also from Washington University, and I were both assigned to the Preventive

Medicine Office at Fort Leonard Wood. After one year of experience at Fort Leonard Wood, they sent Dr. Winter to Walter Reed and left me as the Chief of Preventive Medicine at Fort Leonard Wood. During those years, we had essentially a health department in that office. We had nurses who took care of the civilian dependents. We had sanitarians who were corpsmen; they did restaurant inspections. We had a civil engineer who worked on sanitation, sewer, and water systems. There was no need for reporting illnesses to us; we just read the morning report and discovered what cases of hepatitis, meningitis or tuberculosis had been admitted and immediately went to see the patients. We did food poisoning investigations and educated troop commanders on the prevention of heat and cold injuries.

There were two vaccines that came out in those two years. In 1962, there was the oral polio vaccine, which had to be given according to a specific protocol, and in 1963, there was the vaccine against measles. It was a big undertaking to give the new vaccines to all of the military troops and their civilian dependents. The State Epidemiologist of Missouri at that time was Dr. Edgar Armistead Belden, Armie Belden, as he was known to his friends. Dr. Belden and the state health officer were very concerned that if we turned this live polio virus loose in the population it would spread to the school children and then all over Missouri. They came down and we listened and talked and agreed that we would conduct a pilot study to examine that hypothesis. That study was done by Dr. Tom Chin, then running a virus laboratory for the U.S. Public Health Service in Kansas City. They found no significant spread of disease among the children.

***Question:* Tell me more about your work history since beginning in preventive medicine?**

***Dr. Donnell*:** After those two years at Fort Leonard Wood, I realized I needed to learn more professionally about preventive medicine and epidemiology so I went to the University of California-Berkeley School of Public Health. There, I completed a Masters of Public Health, which included courses in public health administration, statistics, environmental health, and epidemiology. After graduating from UC-Berkeley in 1965, I spent the following year with the California Department of Health in their cancer registry unit. Then I came to the University of Missouri-Columbia to teach Epidemiology. The faculty at that time was trying to create a School of Public Health. We drew faculty from the Veterinary School and the Economics Department; Richard Wallace was one of the professors in our group. We brought together different disciplines and the organization was called Community Health and Medical Practice. There were family practitioners, physical medicine, and public health specialists all in the same group. We developed a 36-hour master's degree, a Masters of Science in Public Health, or MSPH. Mike Sanford, the city health commissioner in Columbia (until his recent death), Bill Johnson, the health director over in Audrain County, and Dr. Richard Biery, the former commissioner of health in Kansas City were some of the graduates of that program.

It was our aspiration at that time to become a fully qualified school of public health. They had set it up with a rotating chairmanship and when I arrived the chairman was a public health physician, Dr. Henry Mack Parrish. As it rotated around, it seemed that the interest in supporting the school of public health began to wane. In fact, Dr. Vernon Wilson, who had been Dean of the School of Medicine, when we started the program, moved on to a position with the Department of Health and Human Services in Washington, D.C. Eventually the momentum toward this kind of program evaporated. I was the director of graduate studies in public health one year by default because other people had left or were no longer interested in promoting it. The program continued for several years and there were many people even after I left, who studied for and obtained the Masters of Science in Public Health.

***Question:* When it became clear that the school would not continue, to what did you direct your attention?**

Dr. Donnell: During those five years when I taught at the University, the Regional Medical Program – President Lyndon Johnson's Program for Heart, Cancer and Stroke – had begun to flourish. The folks who ran that program had the marvelous idea of moving research out of the academic institution and put it into practice as rapidly as possible. The idea was to get communities to create projects and community hospitals to discover ways to improve health care and to translate research into practice. There was much talk about building a network of phone lines that would connect all of these practitioners. In that program, I worked at assembling the epidemiological data on heart, cancer and stroke. We did descriptive epidemiology on those illnesses and provided the data to local hospitals to assist them in the planning and evaluation of treatment programs. My major reason for coming to Columbia had been to teach, and that was being frustrated. I had just gotten my board certification in General Preventive Medicine and a salary increase was not in the budget. So one day I was talking by telephone with Dr. Herbert Domke, who by then had become the State Health Officer in Jefferson City. Dr. Armie Belden had retired the year previous and they had not filled his position. He made me an offer that I couldn't refuse and I began to commute to work in Jefferson City in 1971.

***Question:* So, how has your work with the Department changed over the years?**

Dr. Donnell: My first title was Director of the Bureau of Communicable Disease Control and at the time, that "bureau" consisted of me and one secretary. A couple of years later I was directing a section of epidemiology and had responsibility for several programs: initially, tuberculosis, immunizations, and communicable disease control, then later, sexually transmitted disease. Eventually, other things were added like dental health, nutrition, Bureau of Narcotics and Dangerous Drugs, and the laboratory. I initially did a lot of communicable disease investigations, outbreak investigations, and kept track of the annual statistics and trends. After a few years, we developed a newsletter, the Missouri Epidemiologist, that's been published since November 1977.

***Question:* Would you describe some of the ways that disease prevalence has changed in Missouri since you began directing Epidemiology?**

Dr. Donnell: When I began, the two major sexually transmitted diseases were syphilis and gonorrhea. We were probably recording several thousand cases of syphilis per year, and that has dramatically decreased. We were seeing several thousand cases of tuberculosis per year and that's down to roughly 184 in 1998. Gonorrhea actually increased for several years, but is now beginning to decrease in prevalence. I don't think when I started that we saw very much (or didn't recognize) giardia, campylobacter, yersinia, or E. coli O157:H7. Legionnaire's disease appeared in 1976 and of course AIDS in 1981.

In 1971, the first summer that I came to work with the Department of Health, we learned about a child being ill, many horses dying, and sparrows falling off the rafters in horse arenas. The MU Vet School studied the horse deaths, an officer from CDC assigned to the St. Louis City Health Department investigated the child's illness and the Centers for Disease Control also came and investigated. Samples of the soil were collected immediately, but it took four years to identify Dioxin in the samples. That discovery set a huge effort in motion on the part of federal and state authorities to find out where it was, dig it all up, incinerate it, and compensate people for the land which they could no longer occupy. That land included the city of Times Beach, which is now Route 66 State Park. That was a major activity that I was very much involved with in those years.

***Question:* Are there a few experiences during your tenure on this job that stand out to you, as especially important or meaningful?**

Dr. Donnell: I think for one, producing the Missouri Epidemiologist Newsletter which now goes out to roughly 10,000 nurses, physicians, veterinarians, hospital infection control people, and public health officials. The newsletter conveys an extensive amount of information about current policies, practices and disease occurrence. I think of building the bureau of communicable disease control from just two people to a unit that now has several people, including nurses, investigators, computer specialists and a physician. Environmental epidemiology is becoming more and more involved with GIS (Geographic Information Systems). The department has started using the GPS, or Global Positioning System, which allows us to identify the precise location of wells under investigation. This information is then used to more accurately track the presence of high bacteria levels and chemical contaminants in water. The network of investigators at the district level is something that I helped to build. This is a network of people who help provide surveillance for disease at six different locations around the state.

Question: **How has your practice of preventive medicine, or the day to day work, changed over the years?**

Dr. Donnell: Computers were filling rooms when I started with the Health Department. At that time, we only had a very remote connection with a big computer somewhere in Jefferson City. Now virtually every employee has a personal computer. This has caused tremendous change in the way we keep track of disease. It has increased the rate at which we can collect data, analyze that data, and transmit that data to the Center for Disease Control. In the first year that I was in the Department of Health, we sent a telegram to CDC once a week. Then, we got a noisy teletype machine, which was followed by something (I cannot remember the name) that was a little bit bigger and better than a teletype. Next, came the computers, and eventually the use of data transmission via modem. This was a major improvement because it allowed for real time two-way communication. In the past, if we needed real time, two-way communication we would have to burn up a lot of hours on the telephone and the amount of data we could send was severely constrained.

Question: **What are some of the interesting variations you have seen in disease prevalence across Missouri?**

Dr. Donnell: There is more tuberculosis in the southern half of the state, roughly divided by the Missouri River. I'm not sure that we fully understand why this is. It may relate to the historic patterns of immigration. It fits into a national pattern of more disease in the southeastern part of the United States, across a long tier of states. There have been outbreaks of measles that were restricted to religious groups that generally avoid vaccines, because they believe that vaccines are not appropriate for their people. One religious group here in Central Missouri had importation of polio several years back. The last known case of polio in Missouri was in that group; they did not think that immunization was appropriate for their people. There has been a significant occurrence of hepatitis A in Missouri in recent years. A lot of that seems to be related to crack cocaine addiction, and the gathering together of people for that purpose. In that context, it is highly likely that adequate sanitation is not a priority, and so transmission is increased among the drug users. Those individuals often work at lower paying jobs where they handle food, which has resulted in some transmission as well. While in general very little has been transmitted at food establishments, we have had several instances in which we have learned of poor sanitation at a food facility and we have had to make the public aware of the problem. I think eventually hepatitis A vaccine will be used widely. It's just beginning to be used now. I think that will be another disease that will become exceedingly rare like polio.

Question: **What are the major areas of focus for your efforts now?**

Dr. Donnell: We are planning a proposal for Pandemic Influenza. This is preparation for the next big one, like the Hong Kong Flu or the 1918 flu that was such a devastation to the nation. We're doing contingency planning. We were awarded some money from the Centers for Disease Control and Prevention to study this contingency in Missouri. We gathered representatives from around the state and use the State Emergency Management Agency headquarters in Jefferson City to begin training these individuals in management of a pandemic influenza. The annual effort to investigate flu outbreaks has been a major activity through the years.

The man for whom I currently work, Garland Land, has been a real leader in Missouri public health. He has been responsible for the vital statistics; working with the birth, death, and hospital discharge information, and the physician and hospital licensure data. He has been pulling all of this together into something that is called MOHSAIC. It is a very large transactional database into which individual patient's data can be entered when they come in for a tuberculosis examination or treatment, a STD or a HIV test, or an immunization. Their data will be available, with appropriate security, so that on a need to know basis, clinicians and investigators will be able to access the information for research or the control of threats to the public health. Everything that has been captured by the Department of Health will flow into a data warehouse that will be available to public health administrators, some researchers, and hospital or health care institution administrators. I think that we are focusing more on the efficient and effective provision of information to the front line troops in public health – the nurses, sanitarians, health educators, and the employees of almost 115 local health departments. In the future, these individuals will have ready access to not only the statistical information we gather, but also to policy and legal information, protocols for the various programs, and health education information. What we do now in the form of a printed newsletter, we are also making available on our home page. This is really very similar to what we were trying to do in the Regional Medical Program in 1970 – bring relevant public health information to the practitioner in a timely fashion. But now we have the tools to accomplish that objective. In 1970, we didn't have the computer satellite links, or the fiber optic network. The state did not have a state data center OCEDA, so I think all these things are coming together.

It is a very exciting time to be interested in more than just seeing one patient at a time and responding to their aches and pains or anxieties. The public health physician is attempting to practice medicine with the community as patient, so it is crucial that public health physicians have a timely and sophisticated understanding of epidemiologic patterns of disease. Understanding differential distributions of disease is necessary in order to modify existing programs or initiate new ones. Because resources are limited, public health physicians need good data to make decisions about how to best serve the public.

Concluding Remarks

Dr. Donnell: Public health as a discipline can have a tremendous impact in our overall health. One of the dramatic examples in our lifetime is the fluoridation of water to prevent dental caries. Years before that it was the discovery and the addition of vitamins to food, and the addition of iodine to salt. If you can help initiate a change like that, then you can essentially prevent disease across the landscape. You take it out of the realm of any one person. I hope that there will be an increase in teaching of epidemiology in the medical schools. MoMed

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Accurate Documentation, Correct Coding, and Compliance: It's Your Best Defense!

Teresa Sue Coles, Esq., MLIS, CPC and Edward F. Babb, MD, CPC

Abstract

This article focuses on the need for physicians to maintain an awareness of regulatory policy and the law impacting the federal government's medical insurance programs, and to internalize and apply this knowledge in their practices. Basic information concerning selected fraud and abuse statutes and the civil monetary penalties and sanctions for noncompliance is discussed. The application of accurate documentation and correct coding principles, as well as the rationale for implementing an effective compliance plan in order to prevent fraud and abuse and/or minimize disciplinary action from government regulatory agencies, are emphasized.

Discussion

According to statistics produced by the Health Care Financing Administration (HCFA), in February of 1999, there are 769,511 actively practicing medical providers with unique physician identification numbers (UPIN), in the United States. What do these physicians and providers have in common? A 70% chance of being audited over the next two years for potential health care fraud and abuse by federal regulatory agencies.

Combating health care fraud and abuse in Medicare, Medicaid, and other health care programs continues to be a federal priority. According to the U.S. Department of Justice, "health care fraud is the crime of the nineties: fraudulent schemes are ever changing and growing more sophisticated; unscrupulous persons and companies can be found in every health care profession and industry; fraudulent schemes targeting health care patients, providers, and plans have occurred in every part of this country."[1]

The Office of Inspector General (OIG), recently conducted an audit of HCFA in which it was estimated that HCFA's payment error rate decreased to 7.1% in 1998 from 11% in 1997. This reduced payment error rate represents a decrease to 12.6 billion dollars in 1998 from 20.3 billion dollars in 1997, and confirms the effectiveness of the government's continuing commitment to combat fraud and abuse in the health care delivery system.

The recently released Department of Health and Human Services (HHS), OIG Work Plan for fiscal year 1999 reaffirms the national emphasis on addressing fraud and abuse issues in health care delivery.[2] All indications are that enhanced government scrutiny of physicians' submission of claims for services rendered will continue well into the next millennium.

In order to meet the increasing demands of government regulators, important steps must be taken by physicians to prevent disciplinary action from government regulatory organizations. While practicing quality medicine, it is imperative that physicians also keep abreast of current changes in policies and directives affecting documentation and coding of their services, and internalize the principles so as to accurately apply this knowledge in their practices. An awareness of the importance of compliance with the applicable regulatory and statutory provisions regarding fraud and abuse, and the sanctions and penalties for noncompliance is equally essential.

A lack of information concerning HCFA policies, the regulations and laws that impact health care management issues, as well as the expanded civil and criminal penalties for fraud and abuse, can only result in documentation deficiencies and incorrect code assignment submitted on claims for reimbursement. The possible consequences of poor coding include an increase in delayed or denied reimbursement or, in the worst case scenario, a heightened risk of triggering an audit and investigation with severe penalties assessed for noncompliance in the event of a prosecution. In that a significant number of the civil claims settlements during the last three years involved some issue of improper documentation and coding of services, this article will provide fundamental information on statutory provisions impacting civil prosecutions, as well as basic principles concerning documentation and coding designed to ensure compliance.

The False Claims Act

The federal False Claims Act (FCA), was signed into law by President Abraham Lincoln in 1863.[3] The original intent of the statute was to encourage private citizens to report and combat fraud committed against the Union during the Civil War. Amendments to the FCA were signed into law in 1986 by President Ronald Reagan. These amendments were intended to strengthen the ability of the government to initiate successful FCA prosecutions.

Today, the FCA provides the federal government with an effective tool to investigate and prosecute physicians in civil health care matters because of its broad reach and the substantial civil penalties and damages that can be imposed under the Act. The requirement that specific intent to defraud be proven was eliminated so that now even unintentional conduct is subject to prosecution. The provisions of the FCA prohibit a physician from: "knowingly" presenting a false or fraudulent claim for payment from the government; presenting a false record or statement to have a false or fraudulent claim paid by the government; conspiring to defraud the federal government; or, using a false record or statement to conceal, avoid, or decrease an obligation to pay money or property to the federal government.

In the event that an investigation shows that false claims have been submitted for reimbursement, the government then evaluates whether the physician "knowingly" presented the false claims or made false statements to get the claims paid. The FCA defines "knowingly" as either having actual knowledge of the falsity of the information, or acting in deliberate ignorance or reckless disregard of the truth or falsity of the information.

Case law indicates that gross negligence is sufficient to support an FCA prosecution. A "pattern or practice" of coding that results in the physician receiving reimbursement for services which are not properly supported by the documentation contained in the medical record may be sufficient to prosecute a physician. The civil monetary penalties that can be imposed for each offense include $5,000 to $10,000 per false claim, in addition to triple damages. The physician who is successfully prosecuted is also responsible for reimbursing the costs expended by the government in bringing the civil action, as well as the attorneys' fees.

The Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA), was signed into law on August 21, 1996, by President William Jefferson Clinton.[4] HIPAA served to strengthen existing fraud and abuse laws with respect to health plans by creating new statutory provisions to combat health care fraud and abuse, particularly in Medicare and Medicaid, and increasing penalties for violations.

HIPAA created a method to combat health care fraud and abuse by providing for a joint program known as the Fraud and Abuse Control Program established by the Secretary of the Department of Health and Human Services, acting through the Office of the Inspector General, and the Inspector General. The purpose of the Program is to coordinate the efforts of federal, state, and local law enforcement programs to control fraud and abuse in health care programs in both the public and private sectors. The Program conducts investigations, audits, evaluations, and inspections relating to the delivery and payment for health care.

HIPAA made significant revisions to the civil sanctions relating to fraud and abuse. Of concern to physicians is the fact that the prior statutory law was amended by increasing the amount of civil monetary penalty that can be assessed for improperly filed claims from $2,000 to $10,000 for each claim. Further, HIPAA added two additional practices to the list of those subject to civil monetary penalties. This includes what is commonly termed "upcoding" which occurs when a physician engages in a pattern or practice of presenting a claim for an item or service based upon incorrect coding, thereby seeking a greater reimbursement than the item or service actually performed. The second practice involves engaging in a pattern or practice of submitting a claim for items or services that the physician knows is not medically necessary.

The level of intent associated with fraud violations punishable by civil penalties was redefined in HIPAA. The language of the Act states that individuals only have to act in "deliberate ignorance" or "reckless disregard" of the truth or falsity of the information submitted in a claim for reimbursement for services provided. There is no requirement that specific intent to defraud be proven.

Accurate Documentation and Correct Coding

In view of the severe civil monetary penalties for noncompliance, the physician must strictly adhere to compliance requirements in order to reduce the substantial risk of being investigated or prosecuted for having engaged in fraudulent or abusive practices.

The documentation of services provided to patients is not only the foundation of health information management, but also the basis for fraud and abuse investigations and the enforcement of compliance. Results of HCFA's claim reviews for fiscal years 1996 and 1997 indicate that insufficient documentation was the leading cause of improperly paid claims resulting in overpayment. It is imperative that physicians understand that the documentation in the medical record must satisfy specific requirements in order to support the level of service or procedures billed, as well as to satisfy the requirements when audited. The appropriate level of documentation is whatever is necessary to assure quality of patient care. It is axiomatic that the medical record must be complete and legible. If it is not legible, it is presumed that the service or procedure was not provided.

The American Medical Association (AMA), has promulgated minimum standards for medical record documentation concerning each patient encounter. According to the AMA, the medical record must include: the reason for the encounter and relevant history; physical examination findings, and prior diagnostic test results; assessment, clinical impression, or diagnosis; treatment plan for care; and, date and legible identity of the physician or medical care provider. If it is not documented, the rational for ordering diagnostic and other ancillary services must be easily inferred. The record must set forth past and present diagnoses which are accessible to the treating and/or consulting physician. The patient's progress, response to and changes in treatment, and any revision in diagnosis should be documented.

The Office of the General Counsel of the American Medical Association concerning its promulgation of a "Federal Fraud Enforcement Physician Compliance Plan" asserts that "...in addition to facilitating high quality patient care, an appropriately documented medical record serves as a legal document to verify the services provided."[5] The CPT and ICD-9-CM codes reported on the claim should be correctly and properly supported by the documentation in the medical record to substantiate the bill submitted. In the event of an audit or investigation, a properly documented medical record may serve as the physician's only incontrovertible source of proof concerning his or her submission of codes for reimbursement.

Compliance Plans

Why do you need a compliance plan? The Office of the Inspector General of the Department of Health and Human Services has stated that any physician who can demonstrate his or her adherence to such a plan will be looked upon more favorably in the event of a government investigation. If the government elects to prosecute, the OIG will consider the existence of an effective compliance program that predated any governmental investigation when considering the appropriateness of imposing administrative sanctions. It is notable, however, that the burden to demonstrate the effectiveness of a compliance plan is on the physician.

An effective compliance plan provides a means of enabling the public and private sectors to interact together to attain the mutual goals of minimizing fraud and abuse with the concomitant goal of ultimately reducing the cost of health care services while improving its quality. By implementing a compliance plan, a physician can fulfill his or her legal duty to ensure that inaccurate or false claims are not submitted for reimbursement to government or private payors.

A compliance plan program may be viewed as "preventive medicine" in that it is a proactive measure to prevent fraud and abuse by formalizing processes designed to identify, investigate, remedy, and prevent violations relating to reimbursement for delivery of health care services.

When developing and submitting claims, the effective compliance plan provides for internal control mechanisms through its written policies and procedures including conducting periodic audits of claims on both a pre-payment and post-payment basis in order to ensure the correctness of the code assignment and reimbursement. The compliance program should ensure that services are billed only when the code utilized is the most appropriate descriptor of the service provided to prevent upcoding problems. Similarly, to satisfy medical necessity requirements, the compliance plan should provide a methodology to ensure that services are billed only if they were ordered by the physician or other authorized person, are covered, and are reasonable and necessary in view of the clinical condition of the patient.

Any prior history of noncompliance with the applicable statutes, regulations, and federal, state, or private health care program requirements will alert the physician to additional risk areas that may require necessary policy measures to be taken in order to avoid recurrences. The identified risk areas should be evaluated and remedial measures should be incorporated into the written policies and procedures developed as part of the compliance program. Implementation of an effective compliance plan will assist the physician to prevent fraud and abuse by ensuring compliance with the applicable federal, state, and local regulations relating to reimbursement for medical services rendered.

An effective compliance program also serves as an "insurance policy" for in the event of an investigation and/or prosecution, a compliance plan may be useful to persuade the government to impose reduced fines for violations, and to exercise less draconian remedies than criminal prosecution and exclusion from participation in the Medicare and Medicaid program. Conduct that may be interpreted as establishing a "pattern and practice" of violations, which constitutes knowledge under the provisions of the FCA, is more likely to be viewed as simple errors or aberrations.

Conclusion

Unfortunately, "just practicing quality medicine" is not sufficient to ensure immunity from the severe consequences of noncompliance resulting from inaccurate documentation and incorrect coding. Physicians must be aware of the future implications of today's business decisions relating to compliance with the applicable regulatory and statutory provisions when submitting claims for reimbursement.

For the physician practicing medicine in today's atmosphere of intense regulatory scrutiny from government agencies, whether it serves as "preventive medicine" or an "insurance policy," an effective compliance plan in conjunction with accurate documentation and correct coding are your best defense! MoMed

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EMTALA

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One of the hottest topics in health care is EMTALA. EMTALA is an acronym for Emergency Medical Treatment and Active Labor Act that was enacted by Congress as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. 1395 dd) this legislation is designed to prevent hospitals from refusing to treat patients or transferring them to "charity hospitals" or "county hospitals" because they are unable to pay or are covered under Medicare or Medicaid Programs. In effect, EMTALA has designated emergency departments as America's health care safety net.

Hospitals with emergency departments that participate in the Medicare program have two basic obligations under EMTALA. First, they must provide a medical screening examination to determine whether an emergency medical condition exists. Second, where an emergency medical condition exists, hospitals must either provide treatment until the patient is stabilized, or if they do not have the capability, transfer the patient to another hospital according to EMTALA provisions. This care cannot be delayed by questions about methods of payment or insurance coverage. Emergency departments also must post signs that notify patients and visitors of their rights to be examined and to receive treatment.

In accordance with Rules of the Department of Health, 19 CSR 30-20.021, Organization and Management for Hospitals:

1. Bylaws of the medical staff shall require that at all times at least one physician member of the medical staff shall be on duty or available within a reasonable period of time for emergency service.
2. Hospital emergency services shall be under the medical direction of a qualified staff physician who is board-certified or board-admissible in emergency medicine...or a physician who is experienced in the care of critically ill and injured patients.
3. Any hospital which provides emergency services and does not maintain a physician in-house twenty-four hours a day for emergency care shall have a call roster which lists the name of the physician who is on call and available for emergency care and the dates and times of coverage. A physician who is on call and available for emergency care shall respond in a manner which is reasonable and appropriate to the patient's condition after being summoned by the hospital.

Among the most challenging mandates of EMTALA is the requirement that an on-call roster of all specialties represented on the medical staff be maintained to ensure that patients needing emergency care can be appropriately evaluated and stabilized before any transfer occurs. Medical staff needs to be proactive in determining how this requirement will be met, rather than leaving the decision-making to the hospital. Medical staff bylaws should state that emergency department coverage requirements **be set by the medical staff.**

AMA policy "urges hospital medical staffs to have written policies and procedures in place to delineate clearly the patient follow-up responsibilities of staff members who serve in an on-call capacity to the hospital emergency department." *AMA policy Compendium, H-130.954 (I-93).*

> Medical staff needs to be proactive in determining how this requirement will be met, rather than leaving the decision-making to the hospital.

An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing that individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs." For example, a pregnant woman in active labor must be admitted and treated until delivery is complete, unless a transfer under the statute is appropriate.

EMTALA governs how patients in unstable medical conditions may be transferred from one hospital to another. Under the statute, hospitals cannot transfer patients unless:

- A patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer, or
- A physician certifies that the medical benefits expected from the transfer outweigh the risks.

If a transfer is made, the transferring hospital must provide the care it can, minimize transfer risks, and provide copies of medical records. The receiving facility must have available space and qualified personnel and agree to accept the transfer and the transfer also must be made by qualified personnel with necessary equipment. Receiving hospitals with specialized capabilities, such as burn units or neonatal intensive care units, are obligated to accept transfers if they have the capacity to treat them. The transferring physician is responsible for the medical care of the patient until they arrive at the receiving hospital.

Although hospitals are required by law to provide emergency care (e.g., a medical exam) for any patient who requests medical assistance (unlike any other specialty), insurance companies are not required to pay. In fact, many managed care plans have created administrative and financial barriers that may interfere with patients getting the care they need in an emergency.

1. To control health care costs, a growing number of managed care plans have been denying claims for legitimate visits to emergency departments, based upon a patient's final diagnosis, not his or her presenting symptoms (e.g., chest pain turns out to be a heart attack).
2. Patients often must follow a cumbersome preauthorization process. This means a patient suffering from alarming and possibly painful symptoms might have to make several telephone calls and experience prolonged waits before obtaining permission from their insurer to go to the emergency department. This decision is made over the phone, not based on an examination, and often by a clerk using predetermined criteria. Patients who do not obtain prior authorization are often denied coverage for appropriate emergency department visits.

HCFA (Health Care Financing Administration) generally contracts with state agencies for handling of complaint investigations. The Missouri Department of Health handles this function through its hospital licensure program. The four most common COBRA/EMTALA violations cited in Missouri are:

1. Hospital policies and procedures to comply with the anti-dumping regulations were not in place.
2. Signs were not posted in the emergency department specifying the rights of individuals with emergency medical conditions and women in labor who come to the emergency department for health care services. Facilities often fail to indicate on the signs whether the hospital participates in the Medicaid program.
3. Medical screening was not appropriate.
4. Inappropriate patient transfers.

Non-compliance with COBRA/EMTALA requirements has broad and deep ramifications. Both HCFA (under the U.S. Department of Health and Human Services) and the HHS Office of Inspector General have administrative enforcement powers with regard to EMTALA violations. There is a two-year statute of limitations for any violation.

1. A hospital is subject to termination of its Medicare provider agreement.
2. A hospital may be fined between $25,000-$50,000 per violation. ($25,000 for a hospital with fewer than 100 beds)
3. A physician can be fined $50,000 per violation (also applies to on-call physicians).
4. A physician can be excluded from Medicare and Medicaid programs.
5. A patient can sue the hospital for personal injury in civil court.
6. A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover damages.

EMTALA is not necessarily violated when a physician conducts a negligent screening examination or when malpractice is an issue. In addition, there is no violation when a patient refused treatment unless there was evidence of coercion by the hospital. Also, a poor patient outcome does not necessarily signal a EMTALA violation, however, an EMTALA violation can occur without a poor patient outcome.

In conclusion, timely and medically sound intake procedures uniformly provided to all patients regardless of health insurance status go a long way toward reducing the likelihood of a COBRA citation. If there is any doubt as to the appropriate course, it is wisest to provide all necessary care, leaving issues of payment to another time and place. MoMed

The Effect of a Community-Based Intimate-Partner Violence Advocacy Program in the Emergency Department on Identification Rate of Intimate-Partner Violence

Karen M. Feighny, PhD; Robert L. Muelleman, MD, FACEP

Abstract

A retrospective medical record review assessed identification rate of women acutely injured by intimate-partner violence before and after implementation of an Emergency Department (ED) intimate-partner violence advocacy program.

After program implementation, the identification rate of intimate-partner violence increased over 40%. Of the 19 physicians in the ED during both time periods, 17 (89%) identified more cases after the program began ($p<0.003$).

Implementation of a community-based intimate-partner violence advocacy program in the ED resulted in an increased identification rate of intimate violence.

Introduction

More than one million women seek medical assistance each year for injuries caused by intimate-partner violence.[1] The ED is the health care location most likely to be accessed by these women;[2] however, the ED is often suboptimal in the recognition of intimate violence.[3]

The poor identification rates have led some to call for universal screening for intimate violence in all female patients.[4] Screening protocols in study settings, using research assistants, have demonstrated improved identification rates.[5] However, an early report of a screening protocol developed for a busy ED, using available staff, showed only 19% of the eligible patients were screened.[6]

Barriers to identification of intimate violence by physicians have been reported.[7,8] Problems identified were time constraints and lack of resources if the diagnosis is made. Screening protocols that don't deal with these concerns may risk not being fully utilized. ED advocacy programs that address these concerns have been described.[9] However, the effect of these programs on intimate-partner violence identification rates is unknown.

The purpose of this study was to determine if a community-based intimate-partner violence advocacy program in the ED, in the absence of a formal screening protocol, increased the identification rate of intimate violence.

Materials & Methods

The study, IRB approved, was conducted at Truman Medical Center (TMC) an urban county hospital that serves as the teaching hospital for the University of Missouri-Kansas City School of Medicine. In 1995, the TMC ED treated 45,000 adult patients.

We retrospectively determined the identification rate of intimate violence in women aged 15-65 years, nine months after the implementation of an intimate-partner violence intervention advocacy program (October 1, 1995 - June 30, 1996) and compared it with the rate during the corresponding nine months one year earlier (October 1, 1994 - June 30, 1995).

For the purpose of the study, intimate violence was identified by the presence of an ICD diagnostic code 995.81 (adult maltreatment syndrome) in one of three diagnostic fields in the computerized ED-log. The medical records of identified women were reviewed to confirm that the assailant was a current or former husband or boyfriend. Data were also collected on age, race, time of visit and treating physician.

The intervention advocacy program (BRIDGE)[9] was designed to lower barriers to the use of community resources by women acutely injured by intimate violence. The program made available to the ED 24 hours daily a trained advocate to meet with consenting identified patients. The advocate made a safety assessment, educated the patient about the cycle of violence and available resources, and assisted in dispositions. The visits lasted an average of 1½ hours.

The program started on October 3, 1995, after a three month preparation period. A one hour orientation for the nursing and physician staff, describing the program and protocols, was held just prior to initiation. A formal departmental universal screening protocol was not present before or after the initiation of the program.

We analyzed differences between pre- and post-program groups for categorical data with Yates' corrected chi-square test. The Mann-Whitney rank sum test was used for ordinal and non-normally distributed data (pre- and post-identification rate of physicians in the ED), and the McNamara test was used to calculate 95% confidence intervals.

Results

During the nine month pre-program phase, 15,760 women aged 15-65 presented to the ED; and 16,759 women, during the nine months after the program began. Intimate violence was identified in 189 women (1.19%; 95% CI, 1.03%-1.31%) prior to the program, and in 283 women (1.69%; 95% CI, 1.50%-1.90%) after the program began. The identification rates after the program began, therefore, increased more than 40% from the pre-program phase.

The women in the pre- and post-groups were similar in age (median 31 years) and time of visit, both $p<0.05$. A greater percentage of the women in the post-implementation group were non-white (80% vs. 63%), $p<0.001$. The racial distribution of women in this study corresponds to the racial breakdown of patients visiting the ED which is 71% African-American, 3% Hispanic, 1% Asian, and 25% white.

There were 19 physicians in the ED during both time periods, and 17 (89%) of these physicians identified more intimate violence cases during the program than before implementation, $p<0.003$.

Discussion

This study shows a significant increase in identification of intimate-partner violence by ED physicians who were present before and after implementation of a community-based intimate-partner violence advocacy program in the ED. These findings suggest that an advocacy program facilitates increased detection rates of intimate-partner violence.

Previous research has shown that screening protocols in a research setting increased identification rates of intimate violence;[5] but in the real-world setting of a busy ED, screening protocols are often not followed.[6] The results of this study demonstrate other ways to improve identification in addition to screening protocols. In this case, it was to offer a program that provided the clinician an opportunity to consult an advocate for patients identified as injured by intimate-partner violence.

This program's purpose was to lower barriers for women to access resources available in the community. An unanticipated benefit was that it may also have made it easier for physicians to ask the appropriate questions to identify intimate violence because of the availability of the program. A recent survey of providers indicated that 55% never or rarely screened for intimate violence.[8] It revealed that 60% believed they didn't have enough time to handle the cases, and 48% expressed frustration over the lack of 24-hour access to a social worker. The BRIDGE program may have addressed these concerns, resulting in a motivation to improve identification.

The 40% increase in identification rate is similar to the 1.8 fold increase described by Olson et al. after restructuring the ED chart to include a specific question about domestic violence.[10] Perhaps a combined approach of improved screening with on-site advocacy would have a synergistic effect on identification rate. The future challenge will be to develop a validated screening tool that is easy to administer by on-duty personnel, and result in on-site referral as necessary.

The identification rates after the program started are lower than the 3%-3.5% rate of women acutely injured by intimate violence found in other studies.[5,10] Because the study design measured identification by ICD diagnostic coding, rather than through interviews by research assistants,[5] or formal chart review,[10] it is likely that we were not able to identify all cases of intimate violence.

In conclusion, the implementation of a community-based advocacy program, in the absence of a screening protocol, corresponded with an increased identification rate of intimate-partner violence. MoMed

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Martin B. Wax, MD, associate professor of ophthalmology and visual sciences at Washington University School of Medicine, received a two-year $50,000 grant from the American Health Assistance Foundation for a research project titled "Antibodies to Optic Nerve Glycosaminoglycans in Glaucoma."

Dennis Choi, MD, PhD, professor of neurology at Washington University School of Medicine, received a one-year $110,000 contract from the American Paralysis Association for a research project titled "Research Consortium on Spinal Cord Injury."

Larry W. Piebenga, MD, Kansas City, and **Charles Cozean, MD**, Cape Girardeau, each received the 1999 Golden Medallion award from the Missouri Society of Eye Physicians & Surgeons. It is the Society's highest award.

In Memoriam

Robert A. Moses, MD, 82, St. Louis, died May 7, 1999. Dr. Moses was an ophthalmologist and a member of the Missouri State Medical Association.

Walton Charles Ingram, MD, 83, Leawood, KS, died May 18, 1999. Dr. Ingram was a general surgeon and a member of the Missouri State Medical Association.

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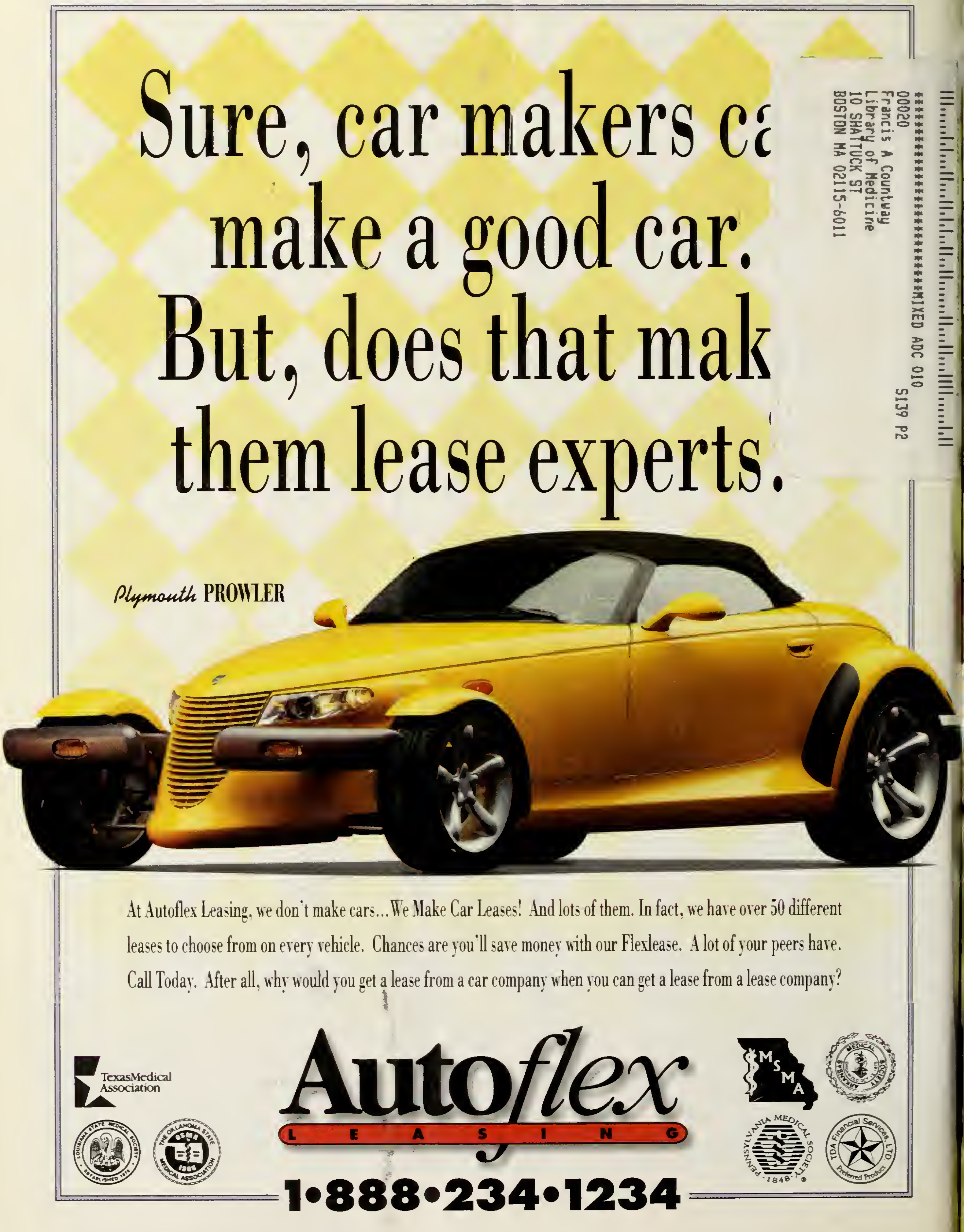

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American Medical Association: 312/464-5000

MSMA Physicians' Health Program: 1-800-274-0933

HCFA: 816/426-5033

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Medicare Part B:
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Missouri Department of Health: 573/751-6400

Missouri Department of Social Services: 573/751-2086

Missouri Patient Care Review Foundation: 573/893-7900
Physician/Provider Information: 1-800-735-6776
Medicare and Insurance Counseling (CLAIM): 1-800-390-3330

Missouri State Bureau of Narcotics and Dangerous Drugs: 573/751-6321

Missouri State Board of Registration for the Healing Arts: 573/751-0098

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MISSOURI MEDICINE

VOLUME 96, NUMBER 8

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Members of the Missouri State Medical Association currently practicing medicine are listed alphabetically by specialty. This roster includes the city in which the physician practices and the code number representing the component medical society to which the physician is a member.

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On the Cover: "Progressive Missouri," by Joseph P. Vorst (1897-1947). This oil on masonite was painted in 1937 and is 55" x 39". It is from the collection of Harry B. Cohen, MD, Columbia, Missouri, who practices anesthesiology in Mexico, Missouri.

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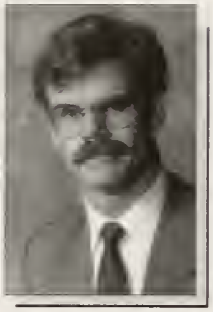

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MSMA Calendar of Events

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August 21-22, 1999
Capitol Plaza Hotel
Jefferson City

November 13-14, 1999
Capitol Plaza Hotel
Jefferson City

January 22-23, 2000
Capitol Plaza Hotel
Jefferson City

June 3-4, 2000
Country Club Hotel
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Annual Convention Dates

April 5-9, 2000
Westin Crown Center
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April 4-8, 2001
Renaissance St. Louis Hotel
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April 10-14, 2002
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St. Louis

April 2-6, 2003
Westin Crown Center
Kansas City

Guide to Membership Benefits

MSMA offers value for your membership dues, the second lowest state medical association dues in the nation! This membership guide explains your benefits as a MSMA member. Contact names and telephone numbers are given, where available. For more information on membership, please contact MSMA at 573-636-5151.

❖ Free subscriptions to *Missouri Medicine, Progress Notes,* and the *Legislative Report*

MSMA members receive *Missouri Medicine*, the monthly journal that informs you of the latest medical, socioeconomic, and technological developments. *Progress Notes* alerts members monthly to current trends in medicine that affect your profession and practice. During the legislative session you receive the *Legislative Report*, a weekly review of activities from the Missouri Capitol. *Contact Barbara Crader at 573-636-5151 for address changes.*

❖ Physician's Guide to Law and Medicine

MSMA offers the Physician's Guide to Law and Medicine to assist members in understanding the laws that affect the practice of medicine. Updated in regularly, all members receive the comprehensive guide and regular updates. *Contact Tom Holloway at 573-636-5151 for more information.*

❖ Continuing Medical Education

MSMA provides continuing medical education opportunities and accredits Missouri institutions and organizations as sponsors for continuing medical education.

❖ MSMA's World Wide Web Site: http:/www.msma.org

Access to the Internet is easy for MSMA members. MSMA will supply necessary software at low prices providing unlimited access to the Internet. The MSMA World Wide Web site features information on legislative, scientific, and socioeconomic issues that is password protected, secure, and educational. *Contact Ron Ellison at 573-636-5151 for more information.*

❖ Credit Card Merchant Services

Central Trust offers MSMA members low rates for processing credit card transactions. You do not need to alter your existing banking relationships to access this program. *Contact Central Trust at 573-634-1232.*

❖ MSMA Gold MasterCard

The MSMA Gold MasterCard offers a significantly higher credit line and unmatched services and features including a free HIV supplemental income protection policy, free credit card registration, additional cards, purchase protection for eligible purchases made with the Gold Card, and around-the-clock customer service. *Contact Tom Holloway at 573-636-5151 for an application.*

❖ Missouri Physicians Health Program

This program helps physicians who have life problems, including substance abuse, mental health issues, litigation stress, and other issues which prevent them from functioning at their best. MPH helps physicians get the support they need to get back into medical practice. *Contact Jack Croughan, MD, or Bob Bondurant, RN, LCSW, at 1-800-274-0933 or 314-371-5225 for more information.*

❖ Collection Services

MSMA-endorsed I.C. Systems, Inc., has a long record of ethical and successful collections for Association members. *Contact I.C. Systems, Inc. at 1-800-685-0595.*

❖ Tax Audit Service

MSMA has endorsed TaxResource, Inc., the largest firm in the nation that offers complete, highly professional audit defense for one small prepaid, tax deductible annual fee. TaxResource provides physicians with expert representation before, during, and after an audit, unrestricted use of the toll-free number for tax counseling, and a quarterly newsletter. *Contact TaxResource at 1-800-922-8348 for more information.*

❖ Physician Placement Service

MSMA has endorsed Medical Employment Directory, Inc. (MED) as their selected health care recruitment firm. MED, Inc., has been actively placing physicians for several years with a retention rate of 99%. *Contact MED at 816-756-3445 or visit their website at www.med-search.com.*

❖ Expired Pharmaceutical Return Program

MSMA introduces “Easy Returns,” a program that provides regulated destruction and documentation for physicians’ unused professional samples, narcotic drugs, and all expired/excess pharmaceuticals. *Contact "Easy Returns" at 1-800-729-3279 or 314-537-4661 for more information.*

❖ Intrav Travel Arrangements

Intrav Travel offers programs that enhance your medical knowledge through scheduled lectures and specifically designed continuing medical education activities, plus the rewards of traveling to some of the world's most intriguing destinations. *Contact Intrav Travel at 1-800-456-0020 or 314-727-0500 for more information.*

❖ Medical Savings Accounts

Self-employed members of MSMA may easily and conveniently purchase their own Medical Savings Account (MSA). Participants will receive a tax break of up to $3,375 per calendar year that may be deducted from their adjusted gross income. Also, as MSA funds accumulate, they earn tax-deferred interest. *Contact MSMA at 573-636-5151 or Golden Rule at 800-444-8990.*

❖ New Car Leasing

MSMA has endorsed Autoflex Leasing as a trusted option for physicians who are either leasing or purchasing a new car. Autoflex has more than 50 lease options available for the vehicle you select. *Contact Autoflex Leasing at 888-234-1234 or visit their website at www. Autoflex.com.*

See the next page for insurance, investment, and retirement options.

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◆ **MonetaMed, A Moneta Group Program**
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700 Corporate Park Dr., #300
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◆ **UNUM Life Insurance Company of America**
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MSMA Policies

Alcohol - Abuse

The MSMA continues to support the work of community-based organizations such as AA, Al-Anon, Narcotics Anonymous, and others, and it reaffirms its support of professional and public education efforts designed to alert people to the dangers of alcohol and drug abuse. In addition, the MSMA supports the Physicians Health Program and similar programs aimed at helping the victims of alcohol and drug abuse to recover successfully. (1987)

Alcohol - Driving

The MSMA encourages a zero tolerance law (defined as blood alcohol of 0.02% or greater) for drivers under 21 years of age. Violation of this law would result in suspension or revocation of driver's license. (1996)

Blood Glucose Monitoring

The MSMA recognizes that a written prescription should be sufficient documentation for Medicaid patients to obtain a blood glucose meter every three years and blood glucose test strips as needed. (1997)

Board of Healing Arts

The MSMA encourages and supports legislation directed toward developing a system of checks and balances with regard to the Board of Registration for the Healing Arts' ability to both investigate and assess (tax) physicians. (1992)

Reporting of Cancer

The MSMA supports efforts to require hospitals to report to the state all malignant neoplasms, with the exception of non-melanomatous cutaneous malignancies. These statistical data are necessary to determine relationships between cancer control efforts and the incidence of cancer in the state. (1982)

Collaborative Practice Guidelines

With the exception of extraordinary circumstances, the MSMA declares that a physician should not engage in a collaborative practice arrangement with more than two full-time equivalent advanced practice nurses and/or physician assistants at one time. Also a system of registration of all collaborative practice agreements, within sixty days of their execution, should be established. (1995)

Chelation Therapy

The MSMA supports the use of IV chelation therapy in FDA-approved applications only. (1990)

Chiropractic

The MSMA is unaware of any scientific evidence that proves that spinal manipulation and adjustment are appropriate treatments for such health conditions as hypertension, heart disease, stroke, cancer, diabetes, and infection. (1981)

DEA Numbers

The MSMA will work for legislation to outlaw the use of DEA numbers for non-controlled substances, the release of DEA number data to non-governmental entities, and the use of the numbers to track prescription histories of physicians for commercial use. (1997)

Definition of Death

A person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he or she has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person shall be considered dead if, in the announced opinion of a licensed physician, based on ordinary standards of medical practice, he or she has experienced a total and irreversible cessation of spontaneous brain functions, including the brain stem. Death shall have occurred at the time when the relevant functions ceased. (1987)

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Ordering of Diagnostic Tests

With the exception of not-for-profit health fairs and mammography screening, the MSMA is opposed to, and considers unethical, the practice of ordering laboratory studies and other diagnostic tests without evidence or indication obtained by a physician in a history and physical examination. (1989; amended 1991)

Disabled

The MSMA is involved in seeking positive ways to encourage training and rehabilitation for disabled persons. The MSMA works with existing organizations to remove physical and emotional barriers that prevent people from working. (1982)

Drugs, Generic Prescribing

The MSMA opposes any interference into the practice of medicine by any governmental agency, third party payer, or commercial dispensing organization through mandated generic or therapeutic substitutions for physician prescriptions. (1992).

Drugs, Physician Dispensing

The MSMA supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with the AMA's published ethical guidelines. (1988)

The MSMA believes that dispensing of drugs and medical devices is part of the practice of medicine and that physicians always have the right to dispense needed drugs and devices. (1991)

Drugs, Therapeutic Substitution

The MSMA opposes the therapeutic substitution of prescribed medications. (1990)

Education, Loans for Medical Students

The MSMA supports continued federal and state subsidized, low-interest loan programs for medical students, with properly enforced repayment. (1982)

Education, School Health

County medical societies are urged to work with local school districts to assist in providing comprehensive health education programs, and the state colleges of Missouri are urged to prepare qualified health instructors trained to integrate health concepts into all the courses they teach. (1972)

Emergency Care

The MSMA supports the American College of Emergency Physicians and the American College of Surgeons standards for direct medical control of prehospital (emergency) care by qualified physicians. (1986)

ERISA

The MSMA supports federal legislation that would modify ERISA to hold self-insured, employee health benefits plans accountable for negligent utilization review decisions and ensure meaningful remedies and fair compensation to patients who are injured as a result of such a decision.

MSMA is in support of federal legislation that is developed to modify ERISA from retroactively changing health care benefits, including monetary policy limitations, after an employee has already contracted an illness or condition.

MSMA advocates that these ERISA modifications be included in federal health system reform. (1994)

Ethics, Education in Medical School

The MSMA supports the teaching of medical ethics to medical students and resident physicians, including information on the workings of professional disciplinary agencies. (1987)

Fee-For-Service Medicine

The MSMA believes that the traditional American fee-for-service medical system should be given equal consideration and equal treatment under the law as other systems of health care provision. (1990)

Fee Splitting

The MSMA reaffirms its support of the AMA Judicial Council's position that the acceptance of financial consideration in exchange for patient referrals, or fee splitting, is unethical and improper. (1985)

Fireworks

The MSMA supports legislation to prohibit the sale of Class C fireworks in the state of Missouri. (1991)

Fluoridation

The MSMA, realizing the medical importance of naturally occurring fluoride taken in proper concentration into the human body, recommends the addition of fluoride to all drinking water systems in Missouri in the concentration of one part per million. (1972)

Governmental Intrusion into Practice of Medicine

The MSMA opposes any further governmental intrusion into the practice of medicine, particularly in the form of rules and regulations from federal agencies. (1992)

Health Care Costs

The MSMA encourages individual physicians to do their part in helping moderate increases in health care costs by avoiding overutilization and by using restraint when considering fee increases, in order to keep them in line with general cost of practice increases. (1989)

Health Care Decision-Making, Right to Refuse Treatment

Believing that critical decisions should be left to the patient, the family, or health care surrogate, and not to the state, the MSMA opposes any legislation that would require court approval for the withdrawal of life support systems, including artificial hydration and nutrition. The MSMA opposes legislation that would impose an arbitrary waiting period before such life support could be withdrawn. (1990)

Health Care Decision-Making, Surrogate Decision-Maker

The MSMA supports legislation allowing competent Missourians to appoint a health care surrogate, empowered by the patient to make medical decisions for him or her if he or she be unable. Such authority should include the power to accept or refuse any and all medical treatment for the patient, including artificial nutrition and hydration. (1990)

Health Delivery or Financing Systems

It is MSMA policy that health delivery or financing systems which grant privileges to limited license health care practitioners should consider the education, training, experience, and demonstrated current competence and apply reasonable and non-discriminatory standards when granting similar privileges to licensed physicians. (1998)

Helmets, Use of

The MSMA urges all motorcyclists to wear protective head gear (helmets) to prevent death and disability. (1977)

The MSMA supports legislation requiring the use of bicycle safety helmets as an effective method of reducing death and injury. (1991)

Hemochromatosis

The MSMA encourages all physicians and health plans to include screening for hemochromatosis as part of routine preventive care and encourages the Missouri General Assembly to protect hemochromatosis patients and others with genetic disease from employment and insurance discrimination. (1997)

Home Health Costs

The MSMA urges Medicare to supply physicians with durable medical equipment and home health care services reports to allow physicians to understand the charges associated with services authorized. (1999)

Hospital Medical Staffs, Autonomy

Since the hospital medical staff is a largely autonomous entity within the hospital, the MSMA supports the securing of separate legal counsel by medical staff members when considering matters of rules, regulations and bylaws. (1985)

Hospital Medical Staffs, Membership

The hospital medical staff cannot be forced to accept for full voting membership any member of the allied health professions. This is in keeping with the MSMA's support of existing JCAHO and AMA guidelines that state no hospital governing board can unilaterally amend the bylaws of a self-governing medical staff, nor can it unreasonably withhold approval of the bylaws. (1987)

The MSMA supports existing state statutes and regulations that delineate requirements for hospital licensure and individual eligibility for medical staff privileges. (1989)

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Human Rights

The MSMA continues to support the dignity of the individual, the importance of human rights and the sanctity of human life, and continues to oppose any discrimination based on an individual's ethnic origin, religious or political beliefs, or any such reprehensible policies. (1986)

Immunization

The MSMA supports American Academy of Pediatrics guidelines for immunization of children. (1987)

Indigent Care

The MSMA urges all physicians to share in the care of indigent patients. (1988)

Insurance Communications

The MSMA urges health insurance companies to cease to communicate abusive and inappropriate language to patients regarding their physicians' fee structures and services. (1985)

Insurance, Maternity Coverage

The MSMA supports inclusion in all insurance policies for those in childbearing years of a clause providing complete maternity coverage. (1974)

Insurance, New Waiting Periods

The MSMA believes employees should not have to undergo a new waiting period for coverage of preexisting illness whenever their employer changes insurance companies, particularly when the change is being made in the interest of controlling health care coverage costs. (1985)

Insurance, Psychiatric Illnesses

The MSMA recommends that the state require all health and accident insurance policies sold in Missouri to provide coverage for psychiatric illnesses equivalent to benefits for other medical and physical illnesses. (1978); Reaffirmed (1985)

Insurance, Right to Know

The MSMA encourages all third party payors to provide an easily understood explanation of their benefits and coverage to their policyholders. (1986)

Insurance, Suicide Attempts

The MSMA believes the insurance industry, including managed care plans, should provide coverage for treatment of patients whose injuries are the result of suicide attempts. (1999)

International Medical Graduates

The MSMA Council and Committees are encouraged to consult with International Medical Graduate groups when subjects of interest come up. All physicians, international medical graduates included, are encouraged to participate in their component medical societies, the MSMA, and the AMA. (1982)

Licensing, Federal

The MSMA opposes any moves to require federal licensure of health manpower. (1976)

Mandated Second Opinion

The MSMA suggests that the physician who renders a mandated second opinion for a proposed surgical procedure not accept that person as a patient for the proposed surgical procedure. (1987)

Mandatory Assignment

The MSMA is opposed to the withholding of medical licensure based on the physician's nonacceptance of Medicare assignment. (1987)

Medical Examiner System

The establishment of a county medical examiner system as a replacement for the county coroner system is strongly recommended. (1971)

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Medicare-Mandated Restrictions

The MSMA opposes Medicare-mandated restrictions on any laboratory tests, referrals, medical examinations or any financial arrangements that might be agreed upon between physician and patient. (1988)

Medicare - Reimbursement to Starting Physicians

The MSMA believes starting physicians should not be reimbursed at a lower rate than other physicians. All physicians should be reimbursed equally for equal services. (1992)

Medicare - Single Statewide Payment Factor

The MSMA supports the adoption by the Health Care Financing Administration of a single, statewide geographic Medicare physician payment adjustment factor for the state of Missouri. (1992)

Medicare - Reimbursement, Hospital DRGs

The MSMA believes it is unfair for Medicare to grant a lower payment to rural hospitals, as compared to urban hospitals, for patient care under the same DRG. (1988); Reaffirmed (1989)

Mergers

The MSMA shall act as physicians' liaison with the state on matters of alliances of payors and providers, conversion of not-for-profit entities and mergers involving payors, insurers, and hospitals. (1997)

MSMF Loans

The Missouri State Medical Foundation requires membership in the Missouri State Medical Association for those medical students eligible for membership and receiving assistance from the Foundation. (1980)

Patient Accountability

The MSMA encourages government, at all levels and whenever possible, to incorporate incentives for patients to behave in ways not detrimental to their health. (1992)

Peer Review Organization Review

The MSMA reaffirms its belief that physicians' work should be reviewed only by other physicians. In addition, the MSMA supports the modification of PRO standards of reviewer anonymity, believing that the reviewers' work should also be subject to review. (1990)

PHO Open Enrollment

The MSMA supports open enrollment of qualified physicians in their hospitals' PHOs in order to preserve physicians' right to participate in any health care plan operating in Missouri. (1994)

Physician and Extender(s) Team

The MSMA acknowledges physicians working as a team with extenders to provide patients access to medical and health care. The MSMA also acknowledges that continued physician involvement and monitoring of the patient

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is essential and that a significant change in the patient's condition requires the physician to reevaluate the patient. Also, under no circumstances, shall a physician relinquish the ultimate care and responsibility of a patient to anyone other than a licensed physician. (1998)

Physician as Patient Advocate

The MSMA affirms its support of the physician in the role of patient advocate in the consumption of health care services, particularly when this role conflicts with the economic goals of the physician's employing third party. (1987)

Physician Leadership in Health Care

The MSMA will actively promote increased physician involvement in administrative and medical decision making. (1998)

Physician, Right to Choose

The MSMA supports the right of each physician to determine for him or herself whom he or she will or will not accept as patients and to exercise his or her choice by the terms of contractual agreements with other physicians, medical groups, third party payers, governmental agencies, hospitals or other institutions. (1981; updated 1992)

Physician, Right to Hospital Privileges

The MSMA is opposed to the granting of hospital privileges to a physician based on that physician's profitability to the hospital. (1988)

Political Process

The Association encourages physicians to become Key Contacts, thereby increasing medicine's role in influencing actions taken by the Missouri General Assembly on issues of importance to our patients and our profession. (1983)

Primary Medical Care

Primary medical care shall be defined as only that care given by a licensed graduate of a medical or osteopathic school. (1977)

Qualifications/Licensure, Disclosure

During the initial encounter and establishment of the physician-patient relationship the MSMA encourages physicians to disclose to patients their identity, credentials, and licensure. (1998)

Referral to Licensed Limited Practitioner

A physician may refer a patient for diagnostic or therapeutic services to another physician, licensed limited practitioner, or any other licensed provider of health care services whenever the physician feels that these services will benefit the patient. As is the case with physician referrals, limited practitioner referrals should be based on the practitioner's individual competence and ability to perform service to the patient. (1981)

References to Physicians and Patients

The MSMA encourages that physicians be referred to as physicians and patients be referred to as patients in internal and external literature and communications such as journals, brochures, media, interviews, lectures, etc. (1998)

Registered Dietitians

The MSMA supports the concept that any person using the title "dietitian" should be a Registered Dietitian. (1987)

School Bus Safety

The MSMA endorses special pre-licensing examination and investigation of prospective school bus drivers in Missouri, according to criteria established by law. (1986)

Seatbelts

The MSMA supports primary enforcement of seatbelt laws and the prohibition of passengers in pickup truck open beds (1997)

Tobacco

The MSMA should pursue an increase in the state tax on cigarettes to fund public education to counter the effects of tobacco advertising and encourage local governments to require retailers to purchase a license to sell tobacco. (1997)

The Missouri State Medical Association and its member doctors should actively support and lobby the Missouri legislature for the following changes in state law.

- The state will license retailers who sell tobacco products. Repeated sales of cigarettes to minors will result in penalties including license revocation.
- All self-service cigarette and spit tobacco displays will be banned except in areas accessible by adults only.
- All cigarette vending machines will be banned.
- The practice of offering free samples and the sale of single cigarettes will be banned.
- All outdoor advertising and store front displays in predominantly residential neighborhoods and within one-half mile of schools, churches, and day care centers will be banned.
- Stricter, more explicit health warning labels on cigarette packs and other tobacco containers will be required.

- Tobacco companies will be required to disclose publicly to the Missouri Department of Health the content of their products.
- Tobacco companies will be required to disclose the nicotine yield in their products.
- Missouri's tobacco-free school law will be expanded to include non-classroom facilities, school grounds, and outdoor areas.
- The per pack state cigarette tax will be increased from 17 cents to 65 cents.
- The state will increase funding for tobacco education and smoking cessation programs.
- The sale of tobacco products over the Internet to Missouri residents would be banned. (1998)

The MSMA and its member doctors should actively support and lobby the Missouri legislature to ban smoking in indoor workplaces, public places, and restaurants. The MSMA also recommends that cities, communities, and private restaurants consider adopting a smoke-free policy in restaurants. (1998)

Universal Referral Form

The MSMA believes that practitioners within the State of Missouri may submit a Universal Referral Form, without penalty, in lieu of a specific form developed by the company for the referral process and that insurers may not delay or otherwise compromise the referral process solely because the referral request is made with the Universal Referral Form rather than the company's own form. (1999)

Utilization Review, Reimbursement

In those hospitals that conduct utilization review of any inpatient care, compensation of physicians for such review is a legitimate expense. The cost of such review should be included in hospital rates and reimbursable costs regardless of the source of payment. (1976)

Voluntary Hospitalist Programs

1. MSMA policy states that (a) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of "admitting officer" or "hospitalist" programs: (b) participation in admitting officer or hospitalist programs developed and implemented by managed care or other health care organizations should be at the voluntary discretion of the patient and the patient's physician; and (c) hospitalist systems when initiated by a hospital or managed care organization should be developed consistent with MSMA policy on medical staff bylaws and implemented with approval of the organized medical staff to assure that the principles and structure of the autonomous and self-governing medical staff are retained.
2. The hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "Hospitalists" and that no punitive measure should be imposed on physicians or patients who decline participation in "hospitalists programs."
3. The MSMA opposes a hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants. (1999)

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Constitution & Bylaws

(adopted 1903, revised April 1999)

Article I. Name of the Association

The name and title of this organization shall be the Missouri State Medical Association.

Article II. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

Article III. Membership

Membership in this Association shall be limited to and include all members in good standing in component societies which hold charters from this Association.

Article IV. House of Delegates

The House of Delegates shall be the legislative body of this Association and shall consist of delegates elected by the component societies as well as all Past Presidents of the Association, the Speaker and Vice Speaker and the Deans of each medical school located in Missouri who are members of the Missouri State Medical Association, who shall serve as Delegates-at-Large. Its Secretary shall be the Secretary of the Missouri State Medical Association.

Article V. Council

The Council shall be the executive body of this Association when the House of Delegates is not in session. It shall consist of the President, President-Elect, Immediate Past President, First Vice President, Secretary, and Treasurer, the duly elected Councilors from each Councilor District and the duly elected Councilors from the Medical Student Section, the Resident Physician Section, the Young Physician Section, the Organized Medical Staff Section, and the International Medical Graduate Section. A majority of voting members of the Council shall constitute a quorum.

Article VI. Council on Ethical and Judicial Affairs

The Council on Ethical and Judicial Affairs shall be the judicial body of the Association. It shall consist of five active members nominated by the President and elected by the House of Delegates.

Article VII. Sessions & Meetings

Section 1. The Association shall hold an annual Spring Convention of the House of Delegates, at places fixed by the House of Delegates, the time of which shall be fixed by the Council. During the Annual Convention, the House shall hold at least three sessions.

Section 2. Special meetings of the Association or the House of Delegates may be called by a two-thirds vote of the Council and shall be called upon a petition signed by members equal in number to one-third of the total number of delegates certified from the last Annual Convention.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice Presidents, a Secretary, a Treasurer, a Speaker and a Vice Speaker of the House of Delegates, and Councilors selected as provided for.

Section 2. The Officers shall be elected annually. The term of Councilors and Vice Councilors shall be two years, except for the duly elected medical student Councilor, resident physician Councilor and organized medical staff Councilor, who shall each be elected for a one-year term. Half of the membership of the Council shall be elected each year. The delegates from each Councilor District shall meet prior to the last day of the Annual Convention and elect the Councilor(s) and Vice-Councilor from that district. The Delegates from the Medical Student Section, the Resident Physician Section, the Young Physician Section, the Organized Medical Staff Section, and the International Medical Graduate Section shall meet prior to the last day of the Annual Convention and elect their respective Councilor. In the event of death, resignation or removal of any Councilor, the Vice Councilor shall automatically fill the vacancy. The Officers shall serve until their successors are elected and installed.

Article IX. Funds, Expenses and Budget

The Council shall submit an annual budget to the House of Delegates. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

Article X. Referendum

At any General Meeting of the Association, it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Association for its vote. A majority vote of all members of the Association shall determine the question.

Petitions signed by 10 percent of the active members of the Association, including petitioners representing at least one-half of the component medical societies, will initiate a referendum regarding changes in the Constitution and Bylaws or questions before the House of Delegates. A two-thirds vote of all active members of the Association responding will determine the question.

Article XI. Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XII. Amendments

The House of Delegates may amend any article of the onstitution by a two-thirds vote of the delegates present and voting in any Annual Convention, provided that such amendment shall have been published twice during the year in the Journal of the Association or sent officially to each component society at least two months prior to the meeting at which final action is to be taken.

Chapter I. Membership

Section 1. Members of this Association shall be those individuals whose names have been certified by secretaries of component societies to the Secretary of this Association that they are duly elected members of a component society and are legally qualified physicians practicing in Missouri, except as otherwise provided. Each member must be of good moral and professional standing, and must not support, nor practice, nor claim to practice any exclusive system of medicine.

Section 2. No person who is under sentence of suspension or expulsion from any component society of this Association or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association.

Section 3. There shall be five classes of members as follows:

Active members shall be limited to those members of component societies who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) if permitted by the bylaws of the component society, members who hold the degree of Doctor of Osteopathy, and (3) are entitled to exercise the rights of active membership in their component societies, as determined by their component societies, subject to the provisions of these Bylaws.

Resident members shall be limited to those members of the Resident Physician Section who are serving a full-time post-graduate training program in a hospital approved by the American Medical Association and shall enjoy all of the privileges of active membership.

Student members shall be limited to those members of the Medical Student Section who are pursuing a course of study leading to the degree of Doctor of Medicine or Doctor of Osteopathy in a medical school approved by the American Medical Association or American Osteopathic Association and shall have all the privileges of active membership.

Honor members shall be limited to Honor members of component societies, which societies have requested that active members who have reached advanced years and have long served the Association and the profession be made Honor members of the Association. They shall enjoy all the privileges of active membership and shall be exempt from the payment of dues.

Special Dues-Exempt members shall be limited to those members of component societies who have been elected to the U.S. Congress, the Missouri State Legislature, or to an office in the executive branch of the state or federal government. They shall be exempt from the payment of dues until the term of their political office expires, and shall enjoy all the privileges of active membership.

Affiliate Members shall be those individuals who contribute to the health care of the public through employment service to MSMA members and component societies and who are not otherwise eligible for active membership. The criteria for affiliate membership and the policies governing the participation of affiliate members shall be established and maintained by the Council. Affiliate members shall have no voting rights nor will this class of membership apply toward House of Delegates or Council representation.

Chapter II. General Meetings

Section 1. The General Meetings shall be open to all registered members and guests.

Section 2. Any paper read before this Association shall be considered for publication in the Journal if the author so desires. Such papers may be given publication priority over regularly submitted papers but shall be subject to the same editorial review and selection policies.

Section 3. No person in the active practice of medicine in the State of Missouri shall appear on the program of the Association unless that person is a member of the Missouri State Medical Association or sponsored by a member. In the latter situation, the paper would be considered that presented by a member.

Chapter III. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Convention.

All resolutions received at the Association office no later than 45 days prior to the opening session of the Annual Convention will be accepted as business of the House of Delegates and will be published in the Delegate's Handbook. Any additional resolutions to be introduced at the opening session must be made available to each member of the House of Delegates at least 24 hours before the opening session. These will be accepted as business of the House at the opening session and will be referred to an appropriate Reference Committee. Resolutions introduced at the opening session, but which did not meet the 24-hour deadline, will be referred to a Reference Committee only if approved by two-thirds of the Delegates voting. Sufficient copies of the resolution, printed in standardized format, or funding for same, must be supplied by the individual or society introducing the resolution.

At the second session of the House of Delegates, introduction of Resolutions would be allowed only if approved by two-thirds of the delegates voting. The same procedure with regard to resolutions would be followed at the last session, but it would then take a unanimous vote of the House to allow such introduction. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishes, condolences, congratulations and others of a personal nature.

Section 2. Delegates to the House of Delegates shall be allotted according to the following formula:

(a). Each component society shall be entitled to send each year one delegate or one alternate for each 25 full paid members or fraction thereof in the Association as of December 31 of the previous year.

(b). One additional delegate or alternate is allowed for each 100 members or major fraction thereof as of December 31 of the previous year.

(c). When a component society's full paid membership as of December 31 of the previous year reaches 1,000, that society shall be entitled to an additional 30 delegates or alternates.

(d). When a component society's full paid membership as of December 31 of the previous year reaches 2,000, that society shall be entitled to an additional 50 delegates or alternates.

(e). Each component society which is composed of two or more counties shall be entitled to at least one delegate from each of the counties having one or more member physicians practicing in the county of which the component society is composed; however, such delegates from multi-county component societies must practice or reside in the county they represent. Alternate delegates may be elected from the entire membership of the component medical societies.

(f). All Past Presidents of the Association, the Speaker and Vice Speaker, and the deans of each medical school located in Missouri who are members of the Missouri State Medical Association shall serve as Delegates-at-Large.

(g). Only duly elected delegates have the privilege of the floor at meetings of the House of Delegates. However, any delegate may request the privilege of the floor for any other individual, which privilege may be granted or denied by the Speaker, subject to disapproval by a majority vote of the House of Delegates.

Section 3. Each Medical School Component Society shall be entitled to send each year two delegates, elected by the component society, to represent the Medical Student Section in the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the component society. Such student delegates shall enjoy all the rights and privileges of all other delegates.

Section 4. The Resident Physician Section shall be entitled to send each year six delegates elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association. Such resident delegates shall enjoy all rights and privileges of all other delegates.

Section 5. The Organized Medical Staff Section shall be entitled to send each year one delegate elected by the Section to the House of Delegates at the Annual Convention. Each delegate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all rights and privileges of all other delegates.

Section 6. The International Medical Graduate Section shall be entitled to send each year one delegate and one alternate elected by the Section to the House of Delegates at the Annual Convention. Each delegate and alternate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all the rights and privileges of all other delegates.

Section 7. The Young Physician Section shall be entitled to send each year one delegate and one alternate elected by the Section to the House of Delegates at the Annual Convention. Each delegate and alternate shall be a member in good standing with this Association and the Section. Such delegates shall enjoy all the rights and privileges of all other delegates.

Section 8. Forty delegates shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Association.

Section 9. From among members of the House of Delegates, the Speaker shall appoint reference committees to which reports and resolutions, on a majority vote of the House of Delegates, shall be referred as follows:

Reference Committee A
Reference Committee B
Reference Committee C
Reference Committee D
Reference Committee E

The Speaker may appoint such other reference committees as deemed necessary, upon approval of the House of Delegates.

The President shall appoint a Committee on Credentials.

Section 10. The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 11. The House of Delegates shall divide the state into Councilor Districts, specifying which counties each district shall include and, when the best interest of the Association and the profession will be promoted thereby, organize in each a district medical society of which all members of the component societies shall be members.

Section 12. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates. Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Section 13. The House of Delegates shall receive and act upon a complete detailed annual audit of receipts and expenses of the preceding year and a proposed budget for the current calendar year which shall have been prepared by the Council and submitted to the component societies at least four weeks prior to the Annual Convention. These shall be published in the Journal.

Section 14. The following shall be the general order of business of the House of Delegates for the first session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Report of officers.
6. Report of committees.
7. Unfinished business.
8. New business.

The following shall be the general order of business of the House of Delegates for the last session of the Convention.

1. Call to order by the Speaker.
2. Report of the Committee on Credentials.
3. Roll Call.
4. Reading and adoption of minutes.
5. Election of officers.
6. Reports of officers.
7. Reports of committees.
8. Unfinished business.
9. New business (Chap. III, Sec. 1).
10. Installation of officers.
11. President's appointments and installation of members to committees.
12. Selection of the place for the next Annual Convention.

At any session of the House of Delegates, the order of business may be changed by a two-thirds affirmative vote of the members present and voting.

Chapter IV. Election of Officers

Section 1. The President, on the first day of the Annual Convention, shall select a Committee on Nominations consisting of fifteen delegates, one from each Councilor District, one from the Medical Student Section, one from the Organized Medical Staff Section, one from the Resident Physician Section, one from the International Medical Graduate Section and one from the Young Physician Section.

The Committee on Nominations shall determine that proposed candidates for office are qualified and willing to serve and shall report at the Second Session to the House of Delegates in the form of a ticket containing the names of one or more members for each of the officers listed in Article VIII of the Constitution, which are to be filled at the Annual Convention, excepting the Secretary and Treasurer, who are elected by the Council from the general membership.

Section 2. All contested elections shall be by written ballot. A majority of the votes cast shall be necessary to elect.

Delegates and Alternates for the American Medical Association shall be elected as follows:

The Nominating Committee shall propose one or more candidates for each delegate position for a full two-year term, one or more candidates for each alternate position for a full two-year term, and one or more names for each unexpired position.

When a nomination for AMA delegate term is contested, the AMA delegates shall be elected by ballot. Each MSMA delegate may have one vote for each delegate to be elected and each vote shall be cast for a different nominee. A nominee is elected if he/she receives votes on the majority of the ballots cast, and has the highest number of votes cast for that position. If all vacancies for AMA delegates are not filled on the first ballot, then subsequent ballots will be taken with the nominee receiving the fewest number of votes cast in each subsequent ballot dropping out of consideration on the next ballot and each MSMA delegate casting one vote for each position in each subsequent ballot until one nominee for each position is elected.

The election for AMA alternates and an election to fill an unexpired term will be conducted in the same manner.

In case no nominee for general offices of the Association (see Article VIII, Constitution) receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when that nominee shall be declared elected.

Section 3. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 4. Delegates present at the Annual Convention from Councilor Districts whose Councilors' and Vice Councilor's terms expire shall hold meetings on or before the morning of the last day of the Annual Convention and elect Councilor(s) and a Vice Councilor for their district for a term of two years. The names of the elected Councilor(s) and Vice Councilors shall be given on prescribed forms to the Secretary for presentation to the House of Delegates. Each candidate for Councilor or Vice Councilor must reside or practice in the district for which that candidate is elected.

Section 5. Each Councilor District shall be entitled to one Councilor for each 400 full paid members or portion thereof and full paid members of the Resident Physician Section training in that Councilor District as of December 31 of the preceding year. Each District shall be entitled to one Vice Councilor.

Section 6. Delegates from the Medical Student Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the medical student component societies shall serve on an annual renewable basis.

Section 7. Delegates from the Resident Physician Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the Resident Physician Section shall serve on an annual renewable basis.

Section 8. The Organized Medical Staff Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the Organized Medical Staff Section shall serve on an annual renewable basis.

Section 9. The International Medical Graduate Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the International Medical Graduate Section shall serve on a two-year renewable basis.

Section 10. The Young Physician Section shall combine and elect one Councilor and one Vice Councilor. The duly elected Councilor and Vice Councilor from the Young Physician Section shall serve on a two-year renewable basis.

Section 11. The Speaker and Vice Speaker shall not serve more than three consecutive terms.

Section 12. The Speaker shall appoint a parliamentarian to serve as such during the sessions of the House of Delegates at each Annual Convention and upon whom the Speaker may call before deciding points of order or procedure.

Chapter V. Duties of Officers

Section 1. The **President**, or a designated representative, shall preside at scientific sessions of the Association. The President shall preside at the House of Delegates in the absence of the Speaker or Vice Speaker and until their successors are elected. The President shall appoint all committees not otherwise provided for. The President shall deliver an annual address at such times as may be arranged and shall perform such other duties as custom or parliamentary usage requires. The President shall be the real head of the profession of the state and assist the Councilors in building up the component societies and in making their work more practical and useful.

Section 2. The **President** and the **President-Elect** shall be members of the Council and shall attend all meetings of the Council. The President-Elect shall assume the office of the President at the Annual Convention following the election to the position of President-Elect. Should the office of President-Elect become vacant through death or otherwise, the Council may fill the vacancy by appointment until the next Annual Convention.

Section 3. The **Vice Presidents** shall assist the President in the discharge of presidential duties. Prior to the meeting of the Nominating Committee, the President-Elect shall recommend to the Nominating Committee the name of a member to serve as First Vice President. In the event of the death, resignation, or removal of the President, the First Vice President shall serve as President for the unexpired term.

Section 4. The **Treasurer** shall give bond in the sum of $50,000. The Treasurer shall demand and receive all funds due the Association, together with bequests and donations. Money shall be paid out of the treasury only on the written order of the President and Executive Vice President, the President and Treasurer, or the Treasurer and Executive Vice President. The Treasurer shall subject the accounts to such examination as the House of Delegates may order, and shall annually render an account of treasury actions and of the state of the funds in his/her hands.

Section 5. The **Secretary** shall attend the General Meeting of the Association and the sessions of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He/She shall be Secretary of the Council and shall keep a record of its proceedings. The Secretary shall be the custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association that come into his/her hands. The Secretary shall provide for the registration of the members and delegates at the Annual Convention. The Secretary shall, with the cooperation of the secretaries of the component societies, keep a register of all the legal practitioners of the state by counties, noting on each the status in relation to the practitioner's component society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. The Secretary shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. The Secretary shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. The Secretary shall supply all component societies with the necessary blanks for making their reports and shall collect from them the regular per capita dues and assessments and turn the same over to the Treasurer.

Chapter VI. Council

Section 1. The Council shall meet during the Annual Convention and at such times as necessity may require, subject to the call of the Chair or on petition of three Councilors. It shall meet on the last day of the Annual Convention to organize. The Council shall elect a Chair and a Vice Chair for a term of one year. The Chair may be reelected to serve not more than four consecutive terms of one year each. The Council shall, through its Chair, make an annual report to the House of Delegates.

Section 2. Each Councilor shall be organizer, peacemaker and censor for his/her district. The Councilor shall visit each county in the district at least once a year for the purpose of organizing component societies where none exists, for inquiring into the condition of the profession, and to keep in touch with the activities of and aid in the betterment of the component societies of the district. The Councilor shall make reports of the work and the condition of the profession of each county in that district to the Council. The necessary traveling expenses incurred by each Councilor in the line of duties herein imposed may be allowed on a properly itemized statement submitted monthly and within the current year, including the expense in attending the Annual Convention of the Association. No Councilor shall be eligible for the position of Delegate to the House of Delegates during his/her term of office as Councilor, nor shall a Councilor vote in the House of Delegates.

Section 3. The Council shall be the executive body of the Association and between the Annual Conventions shall exercise the power conferred on it by the House of Delegates under the Constitution and Bylaws.

Section 4. Charters shall be issued to component societies only on approval of the Council and shall be signed by the President and Secretary of this Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 5. In sparsely settled sections, the Council shall have authority to organize the members of two or more counties into societies, to be suitably designed so as to distinguish them from district societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 6. The Council shall provide for and supervise the issuance of all publications of the Association including proceedings, the transactions and memoirs, and shall have authority to appoint an Editor and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members, to be known as a Committee on Auditing and Appropriations, shall audit all accounts of this Association. The Council shall adopt an annual budget providing for the necessary expenses of the Association for the following calendar year. This budget shall be prepared and presented for consideration in the last quarter of each year by the Committee on Auditing and Appropriations. A complete and detailed report shall be submitted to the component societies as provided in Chapter III, Section 13. The Council shall submit an annual report to the House of Delegates which shall specify the character and cost of the publications of the Association, the amount and character of all its property, and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

Section 7. The Council shall appoint, at least six months prior to the Annual Convention, a committee consisting of three of its members to be known as the Committee on Arrangements for the Annual Convention. On recommendation of the Committee, the Council shall appoint a Chair of a Local Committee on Arrangements, who shall be a member of the component society of the county in which the Annual Convention is to be held, and who shall appoint and organize from the members of the component society the personnel of the Local Committee on Arrangements. The Local Committee on Arrangements shall serve as host for the Annual Convention and shall also act in an advisory capacity for the staff of the Executive Vice President of the Association, who is responsible for arrangements for the Annual Convention.

Section 8. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Conventions of the House of Delegates; the appointee shall serve until the successor has been elected and has qualified.

Section 9. The salaries of all employees of the Association shall be fixed by the Council.

Section 10. The Council shall provide such headquarters for the Association as may be required to conduct its business properly.

Section 11. The Council shall be empowered to elect an Executive Vice President and such other personnel as may be necessary, who need not be members of the Missouri State Medical Association, each of whom shall perform such duties as the Council may designate and receive such salary and serve for such periods and under such conditions as the Council may determine.

Chapter VII. Committees and Commissions

Section 1. Standing Committees of the Missouri State Medical Association, the Chairs of which shall be appointed by the Association President unless otherwise provided in these Bylaws, will be as follows:

Executive Committee.
Committee on Constitution and Bylaws.
Committee on Publication.
Committee on Legislative Affairs.
Committee on Planning.
Physicians Health Committee.

The **Executive Committee** shall consist of the Association President, the Immediate Past President, President-Elect, First Vice President, Secretary, Treasurer, Council Chair and Council Vice Chair. The President of the Association shall be Chair of the Executive Committee. The Executive Committee shall plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Vice President's Office between meetings of the Council, but shall be responsible at all times to the Council.

The Committee on **Constitution and Bylaws** shall consist of five members named by the President and shall propose such amendments to the Constitution and Bylaws as are deemed wise and expedient and bring before the House of Delegates such amendments as it or other members of the Association may present for consideration. The President shall appoint one member for one year, two members for two years and two members for three years. As the term of each expires, a successor shall be appointed for a term of three years.

The Committee on **Publication** shall consist of five members and be appointed annually by the Council and shall be responsible for general publication and distribution policies of the Journal. The editor of the Journal shall be designated by the Council and also shall serve as Chair of the Committee on Publication. The Editor shall be empowered to nominate an Editorial Board, subject to approval by the Council. The members of the Editorial Board will assist the Editor in soliciting, preparing and reviewing material for publication in the Journal.

The Committee on **Legislative Affairs** shall consist of five members of the Association, appointed annually by the President. The Committee shall consider legislative proposals affecting health problems of the people of the state and the practice of medicine and shall make recommendations to the Council and the House of Delegates as well as directing staff activities in such matters.

The **Planning Committee** shall consist of ten members to be appointed by the President. Two members shall be appointed for one year, two for two years, two for three years, two for four years and two for five years. As the term of each expires, a successor shall be appointed for a term of five years. In making such appointments, the President shall be governed by experience of the member, the size of the respective medical society and geographical area, so as to have a representative committee. Age of the members shall be considered to the end that one-third to one-half of the committee shall be of an age group that should contemplate ten to twenty years more of active practice.

The **Physicians Health Committee** shall consist of members of the Association appointed by the President for a term of three years. The Physicians Health Committee shall plan and execute programs of professional assistance for members of this Association who may require assistance to continue or return to their professional activities.

The Committee shall evaluate, maintain, or monitor the quality and utilization of health care services or exercise any combination of such responsibilities of the members in this program.

Section 2. Standing Commissions of the Missouri State Medical Association, who shall be responsible to the Council and whose Chairs shall be appointed by the Association President, will be as follows:

Commission on Public Affairs.
Commission on Medical Economics, Third Party Medicine and Governmental Relations.
Commission on Continuing Education and Health Manpower.
Commission on Medical-Legal Affairs.
Commission on Interspecialty Medicine.

Subsec. a. The standing commissions, unless otherwise provided in these Bylaws, shall consist of fifteen members serving three-year terms and the terms will be staggered so that the President will appoint five members of each Commission each year. Initially, the President will appoint five members to one-year terms, five members to two-year terms and five members to three-year terms and no member shall serve more than two consecutive terms.

Subsec. b. The Chair of each Commission may appoint Ad Hoc Committees to carry out the Commission's programs. These Ad Hoc committees may include any Missouri State Medical Association member.

Subsec. c. The Chair of the Council shall appoint each year an appropriate Councilor to serve as advisor to each respective Commission.

The Commission on **Public Affairs** shall plan and execute programs designed to enhance the relationship between the public and the medical profession. The Commission shall have responsibility in the fields of industrial health, environmental health, medicine and religion, trauma, disaster medical care and national defense and other public matters.

The Commission on **Medical Economics, Third Party Medicine and Governmental Relations** shall keep close liaison and work with peer and utilization review mechanisms, insurance intermediaries and governmental agencies.

The Commission on **Continuing Education and Health Manpower** shall determine the character and scope of the scientific proceedings of the Association for each Annual Convention as well as to make all arrangements for such Annual Convention, subject to the instructions of the House of Delegates. The Commission shall also be responsible for the entire continuing education program of the Association, shall have all matters pertaining to hospitals referred to it, shall carry on all programs in the recruitment of health manpower in professional as well as in allied health fields and shall be responsible for programs in the rural health field.

The Commission on **Medical-Legal Affairs** shall investigate and study medical-legal matters affecting the practice of medicine, make recommendations to the Council and House of Delegates and also make certain that all Association members are kept informed of important developments in this field. The Commission also may work with similar groups formed by the State Bar Association on matters of joint interest and concern as well as with governmental and insurance agencies in this field.

The Commission on **Interspecialty Medicine** shall be composed of one representative of each statewide specialty group as recognized by the Association Council. The President of the Missouri State Medical Association shall appoint annually to the Commission a representative from each of the authorized groups as submitted to the President by the specialty organization. In the event that such a nominee is not submitted by an organization, the Association President may designate a member of the specialty group to serve on the Commission.

The Commission shall be charged with the responsibility of reviewing organization problems with respect to scientific programs, socioeconomic and legislative matters that affect their particular specialties; in addition, the Commission shall have the responsibility for programs and activities in fields relating to disease and health services involving the citizens of our state and such other matters as the Council shall direct. Also, the Commission shall provide close liaison between the various specialty organizations and the Missouri State Medical Association.

Section 3. Fifty percent of a Committee or a Commission should be present at an official meeting to constitute a quorum.

Section 4. Special committees may be appointed by the President or the Council as circumstances may demand.

Chapter VIII. Medical Student Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also students at an accredited medical school in the state of Missouri. The Section shall be the unifying body for the independent Medical School Component Societies in the state.

Section 2. Governing Council. There shall be a Governing Council of the Medical Student Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members of the Governing Council. There shall be five voting members of the Governing Council, consisting of the officers, the Student Councilor and the Student Vice Councilor.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d). Secretary/Treasurer. The Secretary/Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Councilor and Vice Councilor. The Councilor and Vice Councilor shall be elected by the members of the respective Medical School Component Society. The Medical School Component Society from which the Councilor and Vice Councilor shall be elected will be on an annual rotating basis.

(f). Delegates. Each Medical School Component Society shall elect two Delegates to represent the Medical Student Section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Councilor and Vice Councilor shall serve one-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Section Meeting. There shall be a meeting of members of the section held prior to each Annual Meeting of the MSMA House of Delegates.

Section 7. Representatives to the Section Meeting. The annual meeting of the Section shall be open to any member of the Medical Student Section.

Section 8. Purpose of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect a Chair, Vice Chair, and Secretary/Treasurer.

(e). To conduct such other business as may properly come before the meeting.

Chapter IX. Organized Medical Staff Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also members of a hospital medical staff in a Missouri hospital, and who are selected by the physician members of their respective medical staffs.

Section 2. Governing Council. There shall be a Governing Council of the Organized Medical Staff Section to direct the programs and activities of the section, subject to the approval of the MSMA Council.

Section 3. Members. There shall be seven voting members of the Governing Council, consisting of the officers, delegate and alternate delegate, elected at the business meeting of the section.

(a). Officers. The officers of the section shall have the following duties and responsibilities:

(b). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(c). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d). Secretary/Treasurer. The Secretary/Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(e). Councilor and Vice Councilor. The Councilor and Vice Councilor shall represent the section on the Council.

(f). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the MSMA House of Delegates.

Section 4. Term. Governing Council members, including the Delegate and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next business meeting of the Section.

Section 6. Business Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 7. Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Organized Medical Staff Section. The representative must be an MSMA member who is an active voting member of the medical staff with clinical privileges at the hospital.

Representatives to the business meeting shall be elected by and from the active voting members of the medical staff of each hospital.

Representatives to the business meeting shall be properly certified by the President or Secretary of the medical staff.

Only duly selected representatives to the Organized Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the MSMA. The meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council of the section and approved by the MSMA Council.

Section 8. Purposes of the Business Meeting. The purpose of the business meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the business meeting prior to the Annual Convention of the MSMA House of Delegates a Chair, Vice Chair, Secretary/Treasurer, Delegate, Alternate Delegate, Councilor and Vice Councilor.

(e). To conduct such other business as may properly come before the meeting.

Chapter X. Resident Physician Section

Section 1. Membership. The Resident Physician Section shall be composed of Resident Members of the Missouri State Medical Association who are serving in approved training programs.

(a). Governing Council. There shall be a Governing Council for the Resident Physician Section. The Governing Council shall consist of the officers of the Resident Physician Section and two members-at-large of the Section. All members of the Governing Council must be Resident Physician members of the Missouri State Medical Association elected by the members attending the Business Meeting of the Resident Physician Section.

1. Duties. The Governing Council shall direct the programs and the activities of the Resident Physician Section.

2. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Resident Physician Section.

Section 2. Officers. The Members attending the Business Meeting of the Resident Physician Section shall elect the following officers, who shall have these duties and responsibilities:

(a). Chair. The Chair shall preside at all meetings of the Governing Council and the Business Meetings of the Resident Physician Section.

(b). Vice Chair. The Vice Chair shall preside at meetings of the Governing Council or the Business Meetings of the Resident Physician Section, in the absence of the Chair or at the request of the Chair.

(c). Secretary. The Secretary shall maintain such records as are required or advisable for the conduct of the activities of the Resident Physician Section.

(d). Councilor and Vice Councilor. The Councilor and Vice Councilor shall represent the section on the MSMA Council.

(e). Delegates and Alternate Delegates. The Delegates and Alternate Delegates shall represent the Section in the MSMA House of Delegates.

Section 3. Business Meeting. There shall be a Business Meeting of members of the Resident Physician Section. The Business Meeting shall be held on a day prior to each Annual Meeting of the House of Delegates.

Section 4. Rules of Order. Only members of the Resident Physician Section shall have the right to vote, but the meetings shall be open to any members of the Missouri State Medical Association. The meeting shall be conducted pursuant to established rules of procedure adopted by the Governing Council.

Section 5. Purposes of the Meeting. The Purpose of the meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To elect a Chair, who shall serve until the conclusion of the next Annual Meeting.

(c). To elect other officers of the Resident Physician Section and two members-at-large of the Governing Council. Those elected shall assume office at the conclusion of the Annual Meeting at which they are elected and shall serve until the conclusion of the next Annual Meeting.

(d). To consider and vote upon such matters as may properly come before the meeting.

Chapter XI. International Medical Graduate Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are also graduates of an international medical school.

Section 2. Governing Council. There shall be a Governing Council of the International Medical Graduate Section to direct the programs and activities of the section, subject to approval by the MSMA Council.

Section 3. Members. There shall be seven voting members of the Governing Council, consisting of the officers, delegate, and alternate delegate, elected at the business meeting of the section.

Section 4. Officers. The officers of the section shall have the following duties and responsibilities:

(a). Chair. The Chair shall preside at the business meetings of the section and at meetings of the Governing Council.

(b). Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair of at his/her request.

(c). Secretary/Treasurer. The Secretary/ Treasurer shall maintain such records and accounts as may be necessary or advisable for the conduct of the activities of the section.

(d). Councilor and Vice Councilor. The Councilor and Vice Councilor shall represent the section on the MSMA Council.

(e). Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members in the MSMA House of Delegates.

Section 5. Term. Governing Council members, including the Delegate and Alternate Delegate, shall serve two-year terms, beginning at the conclusion of the Annual Convention at which they were elected.

Section 6. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Annual Meeting of the Section.

Section 7. Section Meeting. There shall be a business meeting of members of the section held prior to each Annual Meeting of the House of Delegates.

Section 8. Representatives to the Section Meeting. The annual meeting of the Section shall be open to any member of the International Medical Graduate Section.

Section 9. Purpose of Section Meeting. The purpose of the Section Meeting shall be:

(a). To hear such reports as may be appropriate.

(b). To consider and vote upon such matters as may properly come before the meeting.

(c). To adopt resolutions for submission by the section to the House of Delegates of the MSMA.

(d). To elect at the section meeting prior to the Annual Convention of the MSMA House of Delegates a Chair, Vice Chair, Secretary/Treasurer, Delegate, Alternate Delegate, Councilor and Vice Councilor.

(e). To conduct such other business as may properly come before the meeting.

Chapter XII. Young Physician Section

Section 1. Membership. Membership in the section shall be limited to Missouri State Medical Association members who are under the age of 41 or are in their first five years of practice.

Section 2. Governing Council. There shall be a Governing Council of the Young Physician Section to direct programs and activities of the section, subject to approval of the MSMA Council.

Section 3. Members of the Governing Council. There shall be eight voting members of the Governing Council, consisting of the officers, delegate, alternate delegate, councilor and vice councilor elected at the business meeting of the section.

(a.) Officers. The officers of the section shall be elected annually and have the following duties and responsibilities.

(b.) Chair. The Chair shall preside at the business meetings of the section and at the meetings of the Governing Council.

(c.) Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at his/her request.

(d.) Secretary/Treasurer. The Secretary/ Treasurer shall maintain such records and accounts as be necessary or advisable for the conduct of the activities of the section.

(e.) Immediate Past Chair. To serve as an Officer of the Young Physician Section.

(f.) Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the section in the MSMA House of Delegates. The Delegate and Alternate Delegate shall be elected in alternate years.

(g.) Councilor and Vice-Councilor. The Councilor and Vice Councilor shall represent the section on the MSMA Council.

(h.) The section shall elect Delegates and Alternate Delegates to the AMA Young Physician Section. The number of Delegates and Alternate Delegates will be determined by the AMA based on young physician membership in Missouri.

Section 4. Term. Governing Council members, including Councilor and Vice Councilor, shall serve two year terms, beginning at the conclusion of the annual convention at which they were elected.

Section 5. Vacancies. Any vacancy occurring on the governing council will be filled at the next business meeting of the section.

Section 6. There shall be a meeting of members of the section held prior to each annual meeting of the MSMA House of Delegates.

Section 7. Representative to the Section Meeting. The annual meeting of the section shall be open to any member of the Young Physician Section.

Section 8. Purpose of the business meeting. The purpose of the business meeting shall be:

(a.) To hear such reports as may be appropriate.

(b.) To consider and vote upon such matters as may properly come before the meeting.

(c.) To adopt resolutions for submission by the section to the MSMA House of Delegates.

(d.) To elect a Chair, Vice Chair, Secretary/Treasurer, Delegate, Alternate Delegate, Councilor and Vice Councilor.

(e.) To conduct such business as may properly come before the meeting.

Chapter XIII. Dues and Assessments

Section 1. (a). The annual dues of this Association shall be set by the Council and payable by January 1 of the year for which they are levied.

Section 2. Three dollars of the annual dues shall be credited to the account of the Journal for each member's annual subscription. The remainder of the amount shall be credited to the general fund of the Association.

Section 3. The House of Delegates may, when in its judgment the best interest of the Association demands, recommend an assessment on each active, resident and student member. Such assessment shall be levied only by consent of two-thirds of the members of the House of Delegates present and voting. Funds obtained from such special assessment shall be allocated only for the purposes for which such assessment is levied and in accordance with substantiating budgets. Unexpended balances from such assessments must be reported to the House of Delegates for reallocation.

Section 4. The Secretary of each component society shall cause to be collected and remitted to the Treasurer of this Association the per capita levies. Upon authorization of any component society, the Treasurer of this Association may collect the per capita levies directly from the members of that component society. Any member whose name has not been reported for enrollment and whose dues have not been remitted to the Treasurer of this Association on or before March 1 shall stand suspended until his/her name is properly reported and his/her dues for the current year are paid. On

December 31 of each year, members delinquent in payment of dues, and assessment if such has been made, or any part thereof shall, ipso facto, forfeit their memberships. No suspended member shall be eligible to register at an Annual Convention.

Chapter XIV. Rules of Conduct

Section 1. The ethical principle governing the members of the American Medical Association shall govern members of this Association.

Section 2. Any member of this Association who testifies as a medical expert witness outside of the specialty of the physician represents unethical conduct. In the future, any physician who testifies as a medical expert witness outside of his/her specialty or logical extension of his/her field of expertise or who interferes with the proper administration of justice by misrepresenting his/her qualifications or giving false or misleading testimony will be subject to expulsion, censorship, or reprimand after due process from the Missouri State Medical Association.

Any member of this Association who testifies as a medical expert witness without meeting the qualifications set forth in this section, shall be subject to expulsion, censorship, or reprimand after a due process hearing as set forth. An expert witness must have basic educational and professional knowledge as a general foundation for his/her testimony and, in addition, have current personal experience and practical familiarity with the problems being considered and be actively engaged in the practice of the medical subject under discussion.

Nothing in the above is to be construed as preventing the treating physician from testifying on the merits of the case.

Chapter XV. Rules of Order

The deliberations of this Association shall be conducted in accordance with usages as defined in *Davis' Rules of Order.*

Chapter XVI. Component Societies

Section 1. All component societies now in affiliation with the State Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Association provided that their Constitutions and Bylaws shall have been submitted to the Council and received its approval.

Section 2. Each component society shall be judge of the qualifications of its members, subject to review and final decision by the Council on Ethical and Judicial Affairs of the State Association. Every reputable and legally qualified physician or medical student who does not practice, nor profess to practice sectarian medicine, and who resides or practices in the same county, who shall apply for membership on the prescribed form and subscribe for the Journal and pay the annual dues and assessments for the current year, shall be eligible for election to membership.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council on Ethical and Judicial Affairs of the State Association shall have final authority to expel a member should a component society fail to do so after being so requested by the Council on Ethical and Judicial Affairs.

The Council, may upon request of a component society, remit the state dues and assessment of a member who has become totally and permanently incapacitated through mental or physical disability and has been a member in good standing during the three consecutive years immediately preceding the disability; provided that the component society shall remit the component society dues of such member.

The Council may, upon request of a component society, remit the state dues and assessments of a deserving member found to fall within what is classified as a hardship case, during the period of said hardship until such time as the dues again become payable; provided that the component society shall remit the component society dues of such member.

A physician living near a component society boundary line may hold membership in that component society most convenient for the physician to attend, on permission of the component society in whose jurisdiction the physician resides.

Section 3. Any member who may feel aggrieved by the action of the component society in suspending or expelling him/her shall have the right to appeal to the Council on Ethical and Judicial Affairs, whose decision shall be final. A component society shall at all times be permitted to appeal or refer questions involving membership to the Council on Ethical and Judicial Affairs of the State Association for final determination.

Section 4. In hearing appeals, the Council on Ethical and Judicial Affairs may admit oral or written evidence or both as in its judgment will most fairly present the facts.

Section 5. When a member in good standing in a component society moves to another jurisdiction in this state, the member shall be given a written certificate of these facts by the secretary of the society, without cost, for transmission to the secretary of the society in the jurisdiction to which he/she moves. Pending the acceptance or rejection by the component society to which the physician moves, such member shall be considered to be in good standing in the component society from which he/she was certified and in the State Association to the end of the period for which dues have been paid.

A member of a component society who moves to and engages in the practice of medicine at a location in another area in which there is a component society shall forfeit membership in this Association and the Secretary shall remove the member's name from the roster of members of the Missouri State Medical Association unless within one year after such change of residence he/she becomes a member of the component society of the area to which he/she has moved.

Section 6. Each component society shall have general direction of the affairs of the profession in its area and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician and medical student in the area. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician and medical student in the area.

Section 7. At some meeting in advance of the Annual Convention of this Association, each component society, the Organized Medical Staff Section, the Medical Student Section, the Resident Physician Section, the International Medical Graduate Section and the Young Physician Section shall elect one or more delegates and an equal number of alternates to represent it in the House of Delegates of this Association, in accordance with Chapter III, Section 2, 3, 4, 5, 6 or 7 of these Bylaws. The Secretary of each component society, the Organized Medical Staff Section, the Medical Student Section, the Resident Physician Section, the International Medical Graduate Section and the Young Physician Section shall send a list of such delegates and alternates to the Secretary of this Association at least sixty days before the Annual Convention. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

Section 8. The secretary of each component society shall keep a roster of its members and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by the Council. He/She shall send a copy of the program of each meeting to the district Councilor and to the Secretary of the State Association.

Section 9. Any component society, in a

manner approved by the State Association, or the State Association with the consent of the component society affected, may undertake, organize and put into effect plans for the medical care of indigent persons or indigent groups, and low-income groups, by agreements with physicians, public officials or others and by the use of contributions, cooperative funds or other means; provided, however, that a free choice of the available and participating physicians in that territory shall be allowed to the patient and that all relationships shall be and remain as though it were strictly an individual employment.

Chapter XVII. Council on Ethical and Judicial Affairs

Section 1. The Council on Ethical and Judicial Affairs shall have original jurisdiction in all questions involving Missouri State Medical Association membership, all controversies arising under the Constitution and Bylaws and under the rules of conduct as outlined in the Bylaws, and controversies between two or more component societies or their members. The Council on Ethical and Judicial Affairs shall be the judicial authority of the Missouri State Medical Association and its decisions shall be final. The Council on Ethical and Judicial Affairs shall also investigate general ethical conditions and matters pertaining to the relations of physicians to one another or to the public and make recommendations to the House of Delegates or the component societies.

Section 2. The Council on Ethical and Judicial Affairs shall be composed of five members elected to five-year terms. Nominees shall be submitted by the President for election by the House of Delegates. Any vacancy occurring on the Council on Ethical and Judicial Affairs shall be filled by nomination of the President and election by the House at its next Convention for the remainder of the unexpired term. The first five members of the Council on Ethical and Judicial Affairs shall be elected on a staggered basis; one for one year, one for two years, one for three years, one for four years, and one for five years.

Section 3. The Council on Ethical and Judicial Affairs shall select a Chair and Vice Chair and it may adopt such rules and regulations as it deems necessary and appropriate for the conduct of its affairs, subject to approval by the Missouri State Medical Association Council.

Chapter XVIII. Amendments

Section 1. These Bylaws may be amended at any Annual Convention by a two-thirds vote of the delegates present and voting at that session, if the proposed amendment has been properly submitted to the House of Delegates and has lain on the table for one day.

Section 2. Upon the adoption of this Constitution and these Bylaws, all previous constitutions and bylaws are thereby repealed.

Chapter XIX. Mission

The Mission of the Missouri State Medical Association is to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri.

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*Dorzab, William, MD, *Raytown*
Gibbons, Robert T. Jr., MD, *Overland Park, KS*
Goldman, Gordon, MD, *St. Louis*
Knowlton, Norman P., III, MD, *Springfield*
Kruse, Carl, MD, *Palmyra*
Miller, Robert, MD, *St. Louis*
Vilmer, Stephen, MD, *Parkville*
Wolfe, James, MD, *Springfield*

Council on Ethical and Judicial Affairs

	Term Expires
*Stephenson, Hugh E., Jr., MD, *Columbia*	2004
Cooper, Thomas J., MD, *Farmington*	2003
Hahn, Frederick W., Jr., MD, *Independence*	2002
Hansbrough, Eugene T., MD, *Poplar Bluff*	2000

Committee on Legislative Affairs

*Kennett, Jerry, MD, *Columbia*
Barbe, David, MD, *Mountain Grove*
Campbell, A.J., MD, *Sedalia*
Chirino, Octavio, MD, *St. Louis*
Dorzab, Linda, MD, *Raytown*
Dorzab, William, MD, *Raytown*
Gibbons, Robert T. Jr., MD, *Overland Park, KS*
Goldman, Gordon M., MD, *St. Louis*
Jantsch, Deborah, MD, *Kansas City*
Jelley, Mrs. Betsy, *Blue Springs*
Knowlton, Norman P., III, MD, *Springfield*
Kruse, Carl, MD, *Palmyra*
Miller, Robert, MD, *St. Louis*
Moritz, K. Lynne, MD, *St. Louis*
Murrell, Mrs. Beverly, *Columbia*
Schaaf, Robert, MD, *St. Joseph*
Sparkman, Thomas, MD, *Cape Girardeau*
Vilmer, Stephen, MD, *Parkville*
Wankum, Robert, MD, *Jefferson City*
Wilkinson, David, MD, *St. Louis*
Wolfe, James, MD, *Springfield*

Committee on Constitution and Bylaws

	Term Expires
*Raborar, Arteso C., MD, *Springfield*	2000
Ciliberti, John, DO, *Kansas City*	2002
Chapman, Jean, MD, *Cape Girardeau*	2002
Lampton, Lawrence M., MD, *Columbia*	2000
Potts, Donald, MD, *Kansas City*	2001

Commission on Continuing Education and Health Manpower

	Term Expires
*Martin, David S., MD, *Chesterfield*	2002
Auner, J. David, MD, *Ironton*	2002
Carmichael, Kim, MD, *St. Louis*	2000
Critchlow, J. Thomas, MD, *Cape Girardeau*	2002
Glover, David, MD, *Warrensburg*	2000
Heimburger, Richard, MD, *Osage Beach*	2000
Hellman, Richard, MD, *N. Kansas City*	2001
Loftus, Loretta, MD, *Kansas City*	2002
Mohsen, Aly, MD, *Springfield*	2001
Munro, J. Stuart, MD, *Kansas City*	2001
Schaaf, Robert O., MD, *St. Joseph*	2000
Trentham, Orin, III, MD, *Joplin*	2000
Winton, Mark D., MD, *Jefferson City*	2002

Commission on Interspecialty Medicine

*Van Way, Charles, III, MD, *Kansas City*
Missouri State Surgical Society
Anderson, Tom, MD, *Columbia*
Missouri Psychiatric Association
Anglen, Jeff, MD, *Columbia*
Missouri State Orthopedic Association
Chehval, Michael, MD, *St. Louis*
Missouri Urological Society
Griesemer, Bernard, MD, *Springfield*
American Academy of Pediatrics, MO Chapter
Gibson, Merlyn, MD, *Columbia*
Missouri Radiological Society
Hanaway, Joe, MD, *St. Louis*
Missouri State Neurological Association
Hruza, George, MD, *St. Louis*
Missouri Dermatological Society
Jimenez, David, MD, *Columbia*
Missouri State Neurosurgical Society
Kletzker, George, MD, *St. Louis*
Missouri Society of Otolaryngology
Korenfeld, Michael, MD, *Washington*
Missouri Ophthalmological Society
Landgraf, James, MD, *Independence*
Missouri Society of Pathologists
Lovinger, Warren, MD, *Nevada*
ACP/MO Society of Internal Medicine
Matson, Jeffery, MD, *Kansas City*
Missouri Society of Anesthesiologists
McCorcle, Marcus, MD, *Springfield*
American College of OB/GYN, MO Section
Munger, Michael, MD, *Kansas City*
Missouri Academy of Family Physicians

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Payne, Meredith, MD, *St. Louis*
Missouri Association of Plastic and Reconstructive Surgery
Siler, Thomas, MD, *St. Charles*
Missouri Thoracic Society
Stricker, Wes, MD, *Columbia*
Missouri State Allergy Association
Szewczyk, Michael, MD, *Columbia*
American College of Emergency Physicians, MO Chapter
Wice, Martin, MD, *St. Louis*
Physical Medicine and Rehabilitation

Commission on Medical Economics, Third Party Medicine and Governmental Relations

	Term Expires
*Copeland, Jeffrey, MD, *St. Peters*	2000
Biery, Richard, MD, *Kansas City*	2000
Biggs, F. Douglas, MD, *St. Joseph*	2002
Buie, Steve, MD, *Kansas City*	2002
Bukstein, Michael, MD, *Hannibal*	2001
Handlin, Larry, DO, *Mexico*	2001
Lentz, Kathy, MD, *Washington*	2001
Lomax, John, MD, *Branson*	2002
McIntire, Timothy, MD, *Jefferson City*	2001
Meyer, Jerry, MD, *Concordia*	2001
Miskovsky, Emil, MD, *St. Louis*	2002
Page, Sam, MD, *St. Louis*	2000
Rogers, James, MD, *Springfield*	2000
Thanawalla, Shaukat, MD, *Mexico*	2002
Walz, Bruce, MD, *St. Louis*	2000

Commission on Medical-Legal Affairs

	Term Expires
*Groshong, Ted, MD, *Columbia*	2001
Amon, Erol, MD, *St. Louis*	2001
Bennett, Kenneth, MD, *St. Louis*	2000
Bever, Grant, MD, *St. Louis*	2002
Branham, Gregory, MD, *St. Louis*	2002
Conant, James, MD, *St. Joseph*	2000
Corrado, Joseph, MD, *Mexico*	2000
Criscione, James, Jr., MD, *St. Louis*	2002
Domann, Darrell, MD, *Springfield*	2001
Morley, Ronald, DO, *Jefferson City*	2002
Robinson, Nicholas, MD, *Kennett*	2001
Snidle, William, MD, *Crystal City*	2000
Taormina, Marc, MD, *Independence*	2001
Threats, Susan, MD, *St. Louis*	2002
Wetzel, Gus S., MD, *Clinton*	2000

Physicians Health Committee

	Term Expires
*Anderson, Thomas, MD, *Columbia*	2001
Lyskowski, John, MD, *Jefferson City*	2002
McIntosh, Donald, MD, *Lee's Summit*	2001
Moore, Richard, MD, *Cape Girardeau*	2002
Moritz, K. Lynne, MD, *St. Louis*	2001
Ryall, Jo-Ellyn, MD, *St. Louis*	2000
Scanlon, Richard, DO, *Springfield*	2002
Sincox, Charles, MD, *Washington*	2002

Committee on Planning

	Term Expires
*Lund, Herluf, Jr., MD, *Chesterfield*	2000
Mayuga, Laureano, MD, *Cabool*	2001
McCray, Stephen, MD, *N. Kansas City*	2000
Michael, Roy, DO, *Jefferson City*	2004
Phillips, Ronald, MD, *Kirksville*	2002
Sudekum, Anthony, MD, *Defiance*	2003
Turner, William, MD, *Nevada*	2002
Weber-Bornstein, Nancy, MD, *Cape Girardeau*	2004
Williams, Starks, MD, *Kansas City*	2003
Zahn, Robert, MD, *Springfield*	2001

Commission on Public Affairs

	Term Expires
*Blaine, James, MD, *Springfield*	2000
Ashby, Jennifer, MD, *N. Kansas City*	2002
Brukardt, Diane, MD, *Columbia*	2001
Bukstein, Michaek, MD, *Hannibal*	2002
Bunge, Nancy, MD, *Mexico*	2002
Coonce, Don, MD, *Cape Girardeau*	2000
Gnatz, Steven, MD, *Columbia*	2002
Kapp, William, MD, *Cape Girardeau*	2000
Lovinger, Warren, MD, *Nevada*	2000
Lyskowski, John, MD, *Jefferson City*	2001
Mason, Mary, MD, *Clayton*	2001
Moritz, K. Lynne, MD, *St. Louis*	2000
Peick, Ann, MD, *St. Louis*	2001
Szewczyk, Michael, MD, *Columbia*	2002
Zylka, Michael, MD, *St. Louis*	2001

Publications Committee

*Thomas, J. Regan, MD, *St. Louis*
Anderson, Phillip, MD, *Columbia*
Daniels, John S., MD, *St. Louis*
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CME Coordinator
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Kansas City, KS 66160
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St. Louis Gynecological Society
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621 S. New Ballas Rd., #4019, Tower B
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Contact: Mrs. Terry Watson

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Tel. 573-636-3366; Fax 573-636-8552

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Chesterfield, MO 63017
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Kansas City, KS 66160
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Kansas City, KS 66160
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St. Louis Society of Medical Oncology
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Missouri Ophthalmological Society, Inc.
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St. Louis, MO 63141
Tel. 314-993-5000

Kansas City Society of Ophthalmology & Otolaryngology
President: John Hunkeler, MD
Contact: Ronald Cosens, Exec. Dir.
Metro Med. of Greater K.C.
3036 Gillham Rd.
Kansas City, MO 64108
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St. Charles, MO 63301
Tel. 314-946-7099

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Jefferson City, MO 65102 1028
Tel. 573-636-5151; Fax 573-636-8552

St. Louis Orthopaedic Society
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Email: semoent@igateway.net

Missouri Society of Pathologists
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702 E. St.
Parkville, MO 64152
Tel. 816-741-8404

Mid-Missouri Pathology Society
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UMC School of Medicine
Dept. PTH
Columbia, MO 65212
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Springfield, MO 65804
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Email: marlena@sprintmail.com

St. Louis Pediatric Society
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224 S. Woods Mill Rd., #210
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Central Society of Physical Medicine & Rehabilitation
Contact: Bob Conway, MD
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Columbia, MO 65212
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SSM Rehabilitation Inst.
6420 Clayton Rd., 6th Fl.
St. Louis, MO 63117
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Missouri Association of Plastic & Reconstructive Surgery
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300 S. Mt. Auburn, #100
Cape Girardeau, MO 63703-8399
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Plastic Surgery Society of Kansas City
President: J. B. Moore, IV, MD
20375 W. 151st
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St. Louis Area Society of Plastic Surgeons
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Chesterfield, MO 63017
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Fax 816-931-8655
Email: pkdcure@pkrfoundation.org

Eastern Missouri Psychiatric Society
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Contact: Ron Garrett, Exec. Dir.
3837 Lindell Blvd.
St. Louis, MO 63708-3471
314-371-5225
Email: rongarrett@sprintmail.com

Central Missouri Psychiatric Society
President: Enrique Dos Santos, MD
Contact: Lee Gibson, Exec. Dir.
1122 Eleventh St.
Boonville, MO 65233
Tel. 660-882-9449
Email: cmps@mid-mo.net

Western Missouri Psychiatric Society
President: James True, MD
Contact: Ronald Cosens, Exec. Dir.
Metro. Med. of Greater K.C.
3036 Gillham Rd.
Kansas City, MO 64108
Tel. 816-361-1771

Missouri Radiological Society
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Kansas City, MO

Greater Kansas City Radiological Society
President: Mordecai Kopperman, MD
6724 Troost, #900
Kansas City, MO 64131
Tel. 816-333-8420

Greater St. Louis Society of Radiologists
President: J. Michael Gennaoui, MD
St. Anthony's Medical Center
10010 Kennerly Rd.
St. Louis, MO 6312 8
Tel. 314-525-1155; Fax 314-525-4141

St. Louis Rheumatology Association
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St. Louis Rheumatology Association
10349 Watson Rd.
St. Louis, MO 63127

American College of Surgeons, Missouri Chapter
President: Brent T. Allen, MD, FACS
5103 Queeny Tower
1 Barnes Hosp. Plz.
St. Louis, MO 63110
Tel. 314-362-7408
Contact: Ms. Linda Wheelen, Chapter Adm.
P.O. Box 4562
Springfield, MO 65808
Tel. 417-869-5222; Fax 417-866-7211

Missouri State Surgical Society
President: Thomas Helling, MD
Contact: Ron Ellison, Exec. Dir.
113 Madison St., P.O. Box 1028
Jefferson City, MO 65102 1028
Tel. 573-636-5151; Fax 573-636-8552

Kansas City Surgical Society
President: William Sclar, MD (1999)
Thomas Helling, MD (2000)
Contact: Kathy Smith
2401 Gillham Rd.
Kansas City, MO 64108
Tel. 816-234-3578; Fax 816-234-3821

St. Louis Surgical Society
President: Terence Wade, MD
310 W. Lincoln St., #210
Belleville, IL 62220
Secretary: Vatche Ayvazian, MD
621 S. New Ballas Rd.
St. Louis, MO 63141
Tel. 314-569-6440

Southwest Missouri Chapter of the American College of Surgeons
President: Charles Dunn, MD
Contact: Karen McDonald, Chapter Adm.
Greene County Medical Society
1200 E. Woodhurst, #D-200
Springfield, MO 65804

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330 1st Capitol Dr., #470
St. Charles, MO 63301
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Kansas City, MO 64131
Tel. 816-333-0500

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6651 Chippewa
St. Louis, MO 63109
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State Map of District & Component Society Boundaries

District 1

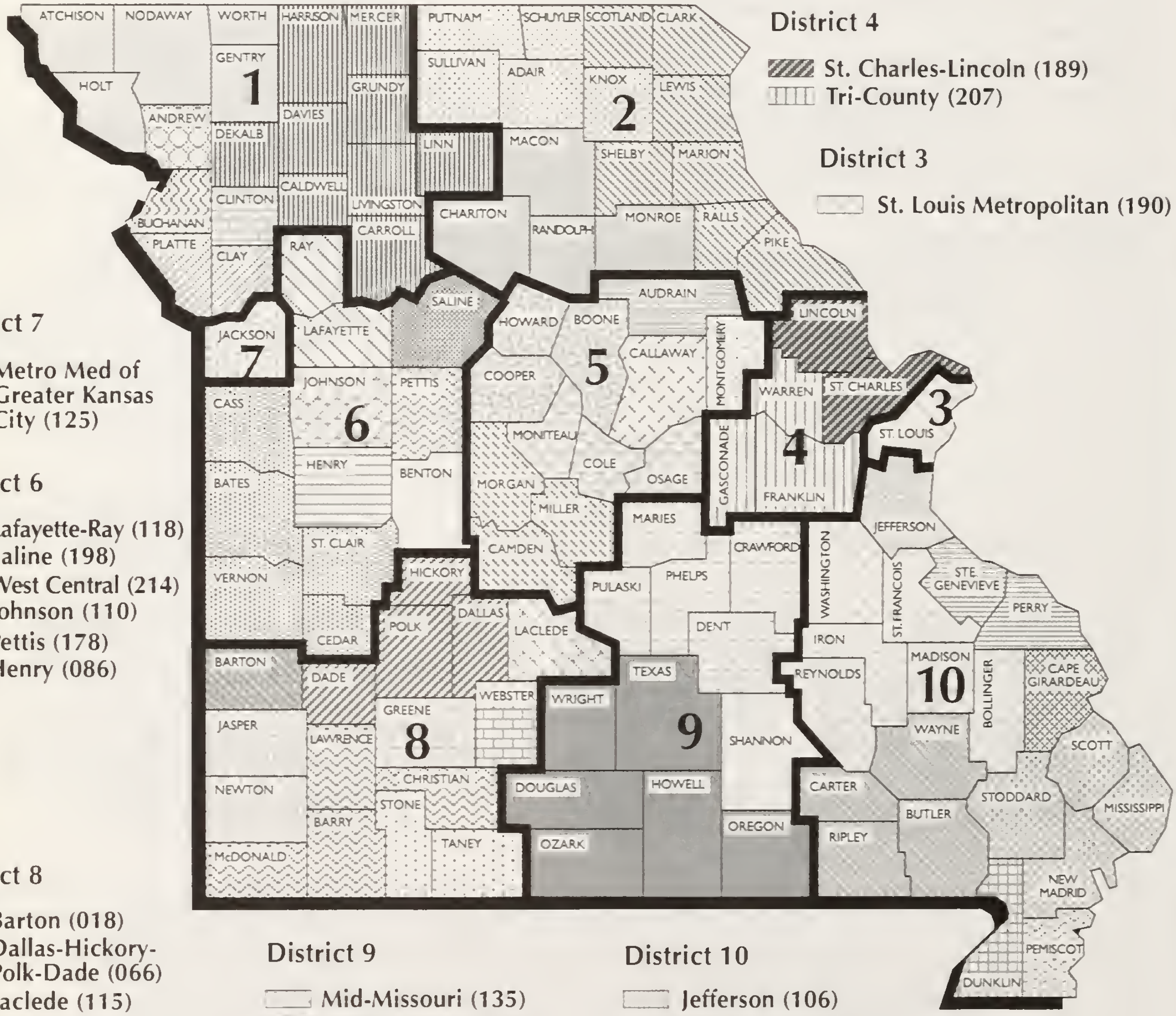
- Andrew (010)
- Northwest (158)
- Grand River (078)
- Buchanan (030)
- Clinton (054)
- Clay-Platte (050)

District 2

- North Central (148)
- Northeast (150)
- Chariton-Macon-Monroe-Randolph (046)

District 5

- Audrain (014)
- Boone (Howard, Cooper) (026)
- Callaway (038)
- Montgomery (146)
- Cole (Moniteau, Osage) (058)
- Lake of the Ozarks (120)


ATCHISON
NODAWAY
WORTH
HARRISON
MERCER
PUTNAM
SCHUYLER
SCOTLAND
CLARK
HOLT
GENTRY
1
SULLIVAN
ADAIR
KNOX
LEWIS
2
GRUNDY
ANDREW
DEKALB
DAVIES
LINN
MACON
SHELBY
MARION
CALDWELL
LIVINGSTON
CLINTON
BUCHANAN
CHARITON
RANDOLPH
MONROE
RALLS
PLATTE
CLAY
RAY
CARROLL
PIKE
SALINE
AUDRAIN
LINCOLN
JACKSON
7
LAFAYETTE
HOWARD
BOONE
CALLAWAY
MONTGOMERY
5
JOHNSON
PETTIS
COOPER
WARREN
ST CHARLES
3
CASS
6
MONITEAU
ST. LOUIS
HENRY
COLE
4
BATES
BENTON
MORGAN
OSAGE
GASCONADE
FRANKLIN
MILLER
MARIES
JEFFERSON
ST. CLAIR
CAMDEN
CRAWFORD
VERNON
HICKORY
PULASKI
PHELPS
WASHINGTON
ST. FRANCOIS
STE. GENEVIEVE
PERRY
POLK
DALLAS
LACLEDE
DENT
CEDAR
IRON
BARTON
TEXAS
MADISON
CAPE GIRARDEAU
DADE
REYNOLDS
10
BOLLINGER
WEBSTER
WRIGHT
GREENE
JASPER
9
8
SHANNON
WAYNE
SCOTT
LAWRENCE
CHRISTIAN
DOUGLAS
HOWELL
CARTER
NEWTON
STODDARD
MISSISSIPPI
STONE
BUTLER
BARRY
OREGON
TANEY
OZARK
RIPLEY
McDONALD
NEW MADRID
PEMISCOT
DUNKLIN

District 4

- St. Charles-Lincoln (189)
- Tri-County (207)

District 3

- St. Louis Metropolitan (190)

District 7

- Metro Med of Greater Kansas City (125)

District 6

- Lafayette-Ray (118)
- Saline (198)
- West Central (214)
- Johnson (110)
- Pettis (178)
- Henry (086)

District 8

- Barton (018)
- Dallas-Hickory-Polk-Dade (066)
- Laclede (115)
- Jasper-Newton Metropolitan (102)
- Ozarks (166)
- Greene (082)
- Webster (210)
- Tri-Lakes (208)

District 9

- Mid-Missouri (135)
- South Central (206)

District 10

- Jefferson (106)
- Mineral Area (138)
- Perry-Ste. Genevieve (174)
- Cape Girardeau Area (042)
- Butler-Wayne-Ripley-Carter (034)
- SEMO (202)
- Dunklin (070)
- Pemiscot (170)

DISTRICT #1

Organized Medical Societies:
Andrew (010), Buchanan (030), Clinton (054), Northwest (158), Grand River (078), Clay-Platte (050)

Counties in District:
Andrew
Atchison
Buchanan
Caldwell
Carroll
Clay
Clinton
Davies
DeKalb
Gentry
Grundy
Harrison
Holt
Linn
Livingston
Mercer
Nodaway
Platte
Worth

DISTRICT #2

Organized Medical Societies:
Chariton-Macon-Monroe-Randolph (046)
North Central (148) Northeast (150)

Counties in District:
Adair
Chariton
Clark
Knox
Macon
Marion
Monroe
Lewis
Pike
Putnam
Ralls
Randolph
Schuyler
Scotland
Shelby
Sullivan

DISTRICT #3

Organized Medical Society:
St. Louis Metropolitan (190)

Areas in District: St. Louis City & St. Louis County

DISTRICT #4

Organized Medical Societies:
Tri-County (207), St. Charles-Lincoln (189)

Counties in District
Franklin
Gasconade
Lincoln
Warren
St. Charles

DISTRICT #5

Organized Medical Societies:
Audrain (014), Boone (026) Callaway (038), Cole (058), Lake of the Ozarks (120), Montgomery (146)

Counties in District:
Audrain
Boone
Callaway
Camden
Cole
Cooper
Howard
Miller
Moniteau
Montgomery
Morgan
Osage

DISTRICT #6

Organized Medical Societies:
Henry (086), Johnson (110), Lafayette-Ray (118), Pettis (178), Saline (198), West Central (214)

Counties in District:
Bates
Benton*
Cass
Cedar
Henry
Johnson
Lafayette
Pettis
Saline
Ray
St. Clair
Vernon

DISTRICT #7

Organized Medical Society:
Metro Med Society of Greater Kansas City (125)
Areas in District: Kansas City & Jackson County

DISTRICT #8

Organized Medical Societies:
Barton (018), Dallas-Hickory-Polk-Dade (066) Greene (082), Jasper-Newton Metropolitan (102), Laclede (115), Ozarks (166), Tri-Lakes (208), Webster (210)

Counties in District:
Barry
Barton
Christian
Dade
Dallas
Greene
Hickory
Jasper
Lawrence
Laclede
McDonald
Newton
Polk
Stone
Taney
Webster

DISTRICT #9

Organized Medical Societies:
Mid-Missouri (135), South Central (206)

Counties in District:
Crawford
Dent
Douglas
Howell
Maries
Oregon
Ozark
Phelps
Pulaski
Shannon*
Texas
Wright

DISTRICT #10

Organized Medical Societies:
Butler-Wayne-Ripley-Carter (034), Cape Girardeau (042) Dunklin (070), Jefferson (106), Mineral Area (138), Pemiscot (170), Perry-Ste. Genevieve (174), SEMO (202)

Counties in District:
Bollinger
Butler
Cape Girardeau
Carter
Dunklin
Iron
Jefferson
Madison
Mississippi
New Madrid
Pemiscot
Perry
Reynolds
Ripley
St. Francois
Ste. Genevieve
Scott
Stoddard
Washington
Wayne

---

* no organized county medical society.

Component Medical Societies

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Arghavendra Adiga, MD
Secretary
803 Hwy. 71W
Savannah, MO 64485 1840
816-324-3121

Audrain County Medical Society
Larry Handlin, DO
Secretary/Treasurer
201 E. Monroe
Mexico, MO 65265
573-581-3240

Barton County Medical Society
Thomas W. Carroll, MD
Secretary
1204 Gulf St.
Lamar, MO 65759 1743
417-682-5584

Boone (Cooper/Howard) Medical Society
Ms. Cathy Rupard
Executive Director
1502 E. Broadway, #203
Columbia, MO 65201
573-874-0783
573-874=0466 (fax)

Buchanan County Medical Society
Mrs. Bea Dobyan
Executive Secretary
5325 Faraon
St. Joseph, MO 64506
816-271-7517
816-271=6695 (fax)

Butler-Wayne-Ripley-Carter County Medical Society
Ms. Carolyn DePriest
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P.O. Box 3986
Poplar Bluff, MO 63901
573-686-3171
573-785=1901 (fax)

Callaway County Medical Society
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211 E. 14th St.
Fulton, MO 65251 2316

Cape Girardeau County Area Medical Society
Ms. Jodi Stahly
Executive Director
#37 Doctors' Park
Cape Girardeau, MO 63703
573-334-5691
573-334=0975 (fax)

Chariton-Macon-Monroe-Randolph Medical Society
c/o MSMA
P.O. Box 1028, 113 Madison St.
Jefferson City, MO 65102 1028
573-636-5151

Clay-Platte Medical Society
Mrs. Jill Watson
Executive Director
3036 Gillham Rd.
Kansas City, MO 64108
816-531-8432
816-531=8438 (fax)

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400 Clay Ave.
Plattsburg, MO 64477 1424

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417-326-6021

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573-888-6603

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417-887=7738 (fax)

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Joplin, MO 64803 2424
417-624-3920
417-624=5447 (fax)

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Ballwin, MO 63011 5115
636-933-1055

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660-747-7751

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Waverly, MO 64096 0169
660-493-2262

Lake of the Ozarks Medical Society
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Camdenton, MO 65020
573-346-5624
573-346=1957 (fax)

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Kansas City, MO 64108
816-531-8432
816-531=8438 (fax)

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913 Stratford
Columbia, MO 65203
573-445-3479
573-446=4318 (fax)

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Ironton, MO 63650
573-546-3434

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111 W. Bates St.
Wellsville, MO 63384 1616

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Hannibal, MO 63401 3179
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660-442-5464

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113 W. Hickory
Neosho, MO 64850
417-451-6574

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Hayti, MO 63851
573-359-2880

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Ste. Genevieve, MO 63670
573-883-7424

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Sedalia, MO 65301 8121
660-827-0423

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30 Timberbrook Dr.
St. Peters, MO 63376
636-940-7000

St. Louis Metropolitan Medical Society
G.R. Garrett
Executive Vice President
3839 Lindell Blvd.
St. Louis, MO 63108
314-371-5225
314-533=8601 (fax)

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1012 N. Main
Sikeston, MO 63801 5044
573-471-0330

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P.O. Box 1100
West Plains, MO 65775
417-257-6777

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Washington, MO 63090-3129
636-239-4144

Tri-Lakes Medical Society
John E. Lomax, MD
101 Skaggs Rd., #202
Branson, MO 65616 2003
417-334-4411

Webster County Medical Society
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Rt. 2, Box 65
Marshfield, MO 65706 9601
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030	Buchanan
034	Butler-Wayne-Ripley-Carter
038	Callaway
042	Cape Girardeau
046	Chariton-Macon-Monroe-Randolph
050	Clay-Platte
054	Clinton
058	Cole
066	Dallas-Hickory-Polk-Dade
070	Dunklin
078	Grand River
082	Greene
085	Greene Residents
086	Henry
102	Jasper-Newton Metropolitan
106	Jefferson
110	Johnson
115	Laclede
118	Lafayette-Ray
120	Lake of the Ozarks
125	Metropolitan Medical Society of Greater Kansas City
126	Metropolitan Medical Society of Greater Kansas City Residents
135	Mid-Missouri
138	Mineral Area
146	Montgomery
148	North Central
150	Northeast
158	Northwest
166	Ozarks
170	Pemiscot
174	Perry-Ste. Genevieve
178	Pettis
189	St. Charles-Lincoln
190	St. Louis Metropolitan
195	St. Louis Metropolitan Residents
198	Saline
202	SEMO
206	South Central
207	Tri-County
208	Tri-Lakes
210	Webster
214	West Central
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218	University of Missouri - Columbia
220	University of Missouri - Kansas City
222	Washington University
224	University Health Sciences College-Kansas City
226	Kirksville College of Osteopathic Medicine

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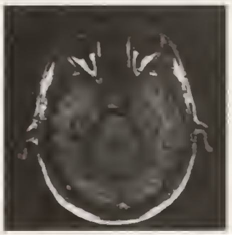

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Adams, Riley R.	042	Cape Girardeau
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Adler, Marlon	027	Jacksonville, FL
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Aff-Drum, Helen	190	St. Louis
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Ahern, Archibald M.	190	St. Louis
Ahlering, George H.	190	St. Louis
Ahlum, Sandra J.	150	Hannibal
Ahlvin, Robert C.	202	Sikeston
Ahmad, Bashir	190	Pacific
Ahmad, Mueed	222	St. Louis
Ahmad, Musaddeque	138	Potosi
Ahmad, Naseer	190	St. Louis
Ahmad, Nusrat J.	190	Chesterfield
Ahmad, Saad	222	St. Louis
Ahmann, Thomas M.	014	Mexico
Ahnemann, Janet L.	086	Clinton
Ailor, Edgar I.	026	Columbia
Ailor, Susan K.	026	Columbia
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Al-Shathir, Saad	102	Joplin
Alaswad, Khaldoon	126	Kansas City
Alba, Laura M.	126	Kansas City
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Alias, Susy	190	St. Louis
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Allan, James R.	150	Shelbina
Allcorn, Donald K.	178	Lincoln
Allen, Arthur A., II	125	Shawnee Mission, KS
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Allen, Jerry H.	082	Springfield
Allen, Jerry H.	207	Washington
Allen, Mark J.	125	Kansas City
Allen, Melvin A.	190	St. Louis
Allen, Robert E.	125	Shawnee Mission, KS
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Allen, William C.	026	Columbia
Allen, William Corwin	026	Columbia
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Allphin, Allan L.	082	Springfield
Allyn, Steven L.	082	Springfield
Almond, Toni	026	Columbia
Almuttar, Wasif F.	158	Maryville
Alsop, Webb S., Jr.	125	Shawnee Mission, KS
Altemeier, William A., III	026	Columbia
Altenbernd, Todd W.	042	Cape Girardeau
Altepeter, H. Martin	190	St. Louis
Alvarez, Juan M.	190	Florissant
Alvarez, Ulises C.	190	Florissant
Alyea, James O.	026	Columbia
Ames, Mary B.	125	Santa Cruz, CA
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Amini, Jafar	002	Shawnee Mission, KS
Amjad, Mohammad T.	190	St. Louis
Ammala, Edward D.	135	Rolla
Amon, Erol	190	St. Louis
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Anderson, David J.	190	St. Louis
Anderson, David R.	042	Cape Girardeau
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Anderson, Philip C.	026	Columbia
Anderson, Raymond B.	125	Shawnee Mission, KS
Anderson, Thomas R.	026	Columbia
Andes, Kellie D.	218	Columbia
Andres, Edward H.	030	St. Joseph
Andrews, Elizabeth J.	082	Springfield
Andrews, Paul E.	082	Springfield
Andrus, Bailey C.	125	Leawood, KS
Anglen, Jeffrey O.	026	Columbia

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Anglo, Luis J. Ballwin	**002**
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Ashcraft, Keith W. Overland Park, KS	**125**
Asher, Irving M. Columbia	**026**
***Asher, Kennett D.** Jackson	**042**
Ashley, Michael E. Springfield	**082**
Ashley, Thomas E. Springfield	**082**
Askew, John H. Sikeston	**202**
Atkinson, John P. St. Louis	**190**
Aubuchon, Craig E. St. Louis	**190**
Auer, Arthur I. St. Louis	**190**
Auer, Christine M. St. Louis	**216**
Aufderheide, G. Russell St. Louis	**190**
Auner, J. David Ironton	**138**
Austin, George M. Blue Springs	**125**
Aveyard, Caitlin E. St. Louis	**222**
Avins, Laurence R. St. Louis	**190**
Avioli, Louis V. St. Louis	**190**
Awadalla, Sylvia St. Louis	**190**
Axness, Mark E. Springfield	**082**
Ayata, Sedat M. Chesterfield	**190**
Aydt, Sarah A. Cape Girardeau	**042**
Aylward, Howard J., Sr. Santa Barbara, CA	**190**
Ayvazian, Vatche H. St. Louis	**190**
Ayyagari, Sujatha R. Potosi	**138**
Azan, Abraham N. Sedalia	**178**
Azan, Kenneth N. Sedalia	**178**

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***Baade, Norman F.** St. Joseph	**030**
Baak, Steven W. St. Louis	**190**
Baalmann, Laura A. St. Louis	**190**
Baber, William W. St. Louis	**190**
Bach, Lysle M. Hannibal	**150**
Back, Donald K. Springfield	**082**
Backer, Robert J. St. Louis	**190**
***Bader, Larry W.** Columbia	**026**
Bagby, Jack M., Jr. Springfield	**082**
Bagby, Stephanie D. Columbia	**218**
Baglan, Robert J. St. Louis	**190**
Bagwe, Lata R. St. Louis	**190**
Bahn, Charles F. Prescott, AZ	**042**
Bahr, Jennifer L. Columbia	**218**
Bailey, Alan H. Springfield	**082**
Bailey, Colin E. Columbia	**026**
Bailey, Gregory J. St. Louis	**190**
Bailey, Sean B. St. Louis	**190**
Bain, Kelly J. New Haven	**207**
Baird, Clint J. St. Louis	**216**
Baird, John B. Columbia	**026**
Baird, Keim L. St. Charles	**189**
Baker, Donald L. Union	**207**
Baker, Eric K. Kansas City	**002**
***Baker, Jay P.** Springfield	**082**
Baker, John H. St. Louis	**190**
Baker, Josephine D. St. Louis	**046**
Baker, Karen S. Springfield	**082**
Baker, Kristie A.R. Overland Park, KS	**125**
Baker, Marion H. Jefferson City	**058**
Baker, Philip J. Lee's Summit	**125**
Baker, Sherwood Columbia	**026**
Baker, Tim E. Washington	**207**
***Balcer, Conrad S.** Jefferson City	**058**
Baldwin, Richard Jr. St. Louis	**190**
Baldwin, Theodore R. Excelsior Springs	**118**
Bale, Robert D. St. Louis	**190**
Balestreri, Laura E. St. Louis	**216**
Ball, David A. Joplin	**102**
Ballinger, Walter F. St. Louis	**190**
Balster, Vernon H. St. Louis	**190**
Bandle, Donald F. St. Louis	**190**
Banerjee, Dilip Washington	**207**
Bang, Dae H. St. Louis	**222**
Banton, M. Roman St. Louis	**190**
Banton, Thomas J., Jr. St. Louis	**190**
Banton, William C., II St. Louis	**190**
Barbe, David O. Mountain Grove	**206**
Barbee, Charles W. Columbia	**026**
Barber, Gregory Kansas City	**125**
Bardsley, John L. St. Louis	**190**
Bare, Chester I., Jr. Raytown	**125**
Bare, Edward F. Tarkio	**158**
Bareis, Robert J. Marshfield	**210**
Barelli, Pat A. Leawood, KS	**125**
Bari, Wagih A. St. Louis	**190**
Barjenbruch, Peggy W. Mexico	**014**
Barker, Edward T. St. Louis	**190**
Barker, Patricia L. Hannibal	**150**
Barlet, Elizabeth Joplin	**102**
Barnett, Floyd A. Paris	**046**
Barnthouse, Joseph R. Kansas City	**125**
Barr, W. Kent N. Kansas City	**125**
Barragan, Hector D. St. Louis	**190**
Barrett, Scott R., Sr. Columbia, MD	**190**
***Barrow, Chelmer L., Jr.** Lake St. Louis	**190**
Barry, Michael O. Cedar Hills, UT	**218**
Barsanti, Mary C. St. Louis	**216**
Bartell, Michael F. St. Louis	**190**
Bartlett, Allison St. Louis	**222**
Bartlett, Hugh C. Rolla	**135**
Bartley, Richard L. Springfield	**082**
Barton, Premsri T. St. Louis	**190**
***Barton, Rod T.** Springfield	**085**
Bartulica, Nicholas St. Joseph	**030**
Bartuski, Allison J. St. Louis	**216**
Bashyakarla, Rajeeva K. Joplin	**102**
Bass, Barry J. Rolla	**135**
Bassett, Gregg E. St. Louis	**002**

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Bassman, Donald R.	**190**	St. Louis
Basu, Devraj	**222**	St. Louis
Batan, Ruby L.	**190**	Chesterfield
Bateman, Timothy M.	**125**	Kansas City
Bates, G. Comer	**050**	Kansas City
Batrash, Ahmad	**126**	Merriam, KS
Batterson, James R., Jr.	**125**	Kansas City
Batts, Barbara A.	**125**	Kansas City
Baudendistel, Lawrence J.	**190**	St. Louis
Bauer, Daniel J.	**190**	St. Louis
Bauer, John C.	**126**	Kansas City
Bauer, John H.	**026**	Columbia
Bauer, Joseph G.	**150**	Hannibal
Bauer, Lafe W.	**125**	Prairie Village, KS
Baughman, Lori C.	**126**	Kansas City
Baula, Armindo G.	**190**	St. Louis
Bauman, Alan E.	**125**	Kansas City
Baumann, Albert R.	**135**	Steelville
Baumann, Daniel J.	**190**	St. Louis
Bauschard, Frederick D.	**190**	St. Louis
Bautista, Joel O.	**046**	Moberly
Bautista, Rogelio L.	**046**	Moberly
Bautz, James B.	**125**	Kansas City
Bauwens, Daniel B.	**190**	Chesterfield
Beal, Catherine E.	**190**	St. Louis
Beall, McPherson S., Jr.	**125**	Kansas City
***Bean, David K.**	**190**	Florissant
Bean, Joseph M.	**026**	Sedalia
Bean, Marchelle J.	**126**	Kansas City
Bean, Melissa M.	**220**	Kansas City
Beardman, Todd	**126**	Kansas City
Beare, Lucia V.	**190**	St. Louis
Beatty, Cassandra	**220**	Highlandville
Beaty, William R.	**190**	Vero Beach, FL
Bechtold, Matthew L.	**218**	Columbia
Beck, David A.	**026**	Columbia
Beck, Marcus R.	**026**	Columbia
Beck, Paul M.	**030**	St. Joseph
Becker, Bernard	**190**	St. Louis
Becker, Gregory L.	**190**	St. Louis
Becker, Robert L.	**190**	St. Louis
Becker, Stanley C.	**190**	St. Louis
Becker, William L.	**190**	St. Louis
Beckerdite, Matthew A.	**218**	Columbia
Beckett, Wm. Wilson	**026**	Columbia
Beckette, Edmund	**190**	St. Louis
Beckman, Robert F.	**190**	St. Louis
Beckmann, Charles R.B.	**125**	Kansas City
Bedwinek, John M.	**190**	St. Charles
Beeks, John W.	**125**	Kansas City
Beggs, Charles W.	**050**	Liberty
Beguin, Everett A., Jr.	**082**	Springfield
Behbahani, Parviz M.	**190**	Bridgeton
Beheler, Edward M.	**030**	St. Joseph
Behrend-Uhls, Ann E.	**042**	Cape Girardeau
Behrends, Steven H.	**125**	Kansas City
Behrens, Donald T.	**190**	St. Louis
Behrens, Gerald L.	**190**	St. Louis
Beitman, Bernard D.	**026**	Columbia
Belden, Jeffery L.	**026**	Columbia
Belen, Marietta	**106**	Festus
Belew, Joe E.	**190**	Chesterfield
Belew, Mark	**190**	Florissant
Bell, Gordon A.	**125**	Lee's Summit
Bell, Malinda H.	**125**	Shawnee Mission, KS
Bell, Martin J.	**190**	St. Louis
Bell, Patricia L.	**218**	Columbia
Bell, Stephen	**190**	St. Louis
Bell, William D.	**220**	Kansas City
Bell, William F.	**125**	Lee's Summit
Bellamy, Bruce G.	**086**	Clinton
Beller, Thomas A.	**125**	Kansas City
Belshe, Sidney B.	**058**	Jefferson City
***Belson, Ian L.**	**125**	Kansas City
Belz, Norbert T.	**082**	Nixa
Bender, Edward	**042**	Cape Girardeau
Benecke, James E., Jr.	**190**	St. Louis
Benedett, Robert E.	**082**	Springfield
Benedict, Christina H.	**222**	St. Louis
Benedict, William W.	**190**	Chesterfield
Bennett, Christina D.	**216**	St. Louis
Bennett, Danny	**125**	Kansas City
Bennett, James D.	**125**	Leawood, KS
Bennett, Kenneth J.	**190**	St. Louis
Benoist, Walter F.	**190**	Bridgeton
Benson, Larry E.	**050**	N. Kansas City
Benson, Ronald G.	**082**	Springfield
Benson, Russell L.	**125**	Kansas City
Bentlage, Charles H.	**102**	Joplin
Bentley, John D.	**082**	Springfield
Benton, Mary Beth	**026**	Columbia
Bercutt, Lawrence D.	**222**	Beverly Hills, CA
Berdy, Gregg J.	**190**	St. Louis
Berdy, Susan S.	**190**	St. Louis
Berg, Leonard	**190**	St. Louis
Berg, Ralph	**190**	St. Louis
Bergmann, Daniel J.	**189**	St. Peters
Bergmann, Martin	**190**	Chesterfield
Berkowitz, Ellis R.	**030**	St. Joseph
Berkowitz, Wallace P.	**190**	St. Louis
Berland, David I.	**190**	St. Louis
Berman, William	**190**	St. Louis
Bernabe, Florinio H.	**190**	St. Louis
Bernabe, Ofelia M.	**190**	St. Louis
Bernard, Lisa	**125**	Kansas City
Berndsen, Gerard H.	**190**	St. Louis
Berner, Carol T.	**082**	Springfield
Bernhardt, Mark	**125**	Kansas City
Berni, Anthony A.	**190**	St. Louis
Bernstein, Aaron M.	**190**	St. Louis
Berry, Danny T.	**042**	Cape Girardeau
Berry, Maxwell G.	**125**	Prairie Village, KS
Berry, Paul T.	**082**	Springfield
Berson, Douglas R.	**190**	Chesterfield
Berwald, David M.	**190**	Bridgeton
Berwald, Irvin I.	**190**	Bridgeton
Beshears, Katherine M.	**220**	Kansas City, KS
Besirli, Cagri G.	**222**	St. Louis
Best, John A.	**190**	Chesterfield
Bettinger, Irene E.	**125**	Kansas City
Bettonville, Peter V.	**190**	St. Louis
Betz, Richard J.	**166**	Neosho
Betz, Robert F.	**166**	Neosho
Beuerlein, Matthew E.	**002**	Kansas City
Bever, Grant A.	**190**	St. Louis
Beyer, Devra	**222**	University City
Bhattacharya, Arjun	**190**	St. Louis
Bhend, Ernest M.	**218**	Columbia
Bhothinard, Bhisit	**034**	Poplar Bluff
Biber, Robert J.	**125**	Independence
Bick, Florence C.	**216**	St. Louis
Biddle, Jason S.	**218**	Columbia
Biek, Richard W.	**190**	St. Louis
Biel, Stanley I.	**190**	Bridgeton
Bieniek, Christopher M.	**150**	Hannibal
Biery, Richard M.	**125**	Kansas City

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***Bieser, R. Dan**	**042**	Cape Girardeau
Biggers, Brian D.	**218**	Columbia
Biggs, Alfred D., Jr.	**125**	Kansas City
Biggs, F. Douglas	**030**	St. Joseph
Biggs, Fred J.	**034**	Poplar Bluff
Biggs, Harry L.	**125**	Galena
Billy, Lawrence J.	**190**	St. Louis
Bindbeutel, Donald A.	**190**	Ballwin
Binz, Donald E.	**189**	St. Peters
Bircher, John L.	**190**	St. Louis
Bird, H. Waldo, Jr.	**190**	St. Louis
Birenboim, Nancy	**125**	Kansas City
Birmingham, Jean E.	**190**	St. Louis
Birnbaum, Elisa H.	**190**	St. Louis
Bishop, Marion D.	**190**	St. Louis
Bizek, J.L.	**166**	Aurora
Black, Brandon R.	**218**	Columbia
Black, David L.	**102**	Joplin
Black, William R.	**102**	Neosho
Blackburn, Michael D.	**026**	Columbia
Blackwell, Charles R.	**190**	St. Louis
Blades, Ross D.	**082**	Springfield
Blaesing, Nicole K.	**218**	Prairie Village, KS
Blaine, James R.	**082**	Springfield
Blair, Jerry R.	**026**	Columbia
Blair, Vilray P., III	**190**	St. Louis
Blake, Kathleen M.	**026**	Columbia
Blalock, Robert W.	**198**	Marshall
Blank, Michael K.	**106**	De Soto
Blanke, Thomas J.	**190**	St. Louis
Blankenship, Dale M.	**042**	Savannah, GA
Blaskiewicz, Robert J.	**190**	St. Louis
Blath, Richard A.	**190**	St. Louis
Blatt, Andrew	**190**	St. Louis
Blatt, Carl F.	**207**	Washington
Blatt, Geoffrey L.	**125**	Kansas City
Blim, R. Don	**125**	Belton
Bliss, Greg A.	**125**	Blue Springs
Block, Arnold S.	**190**	St. Louis
Blood, Belinda	**222**	St. Louis
Bloom, Stephen A.	**125**	Overland Park, KS
Bloomberg, Gordon R.	**190**	Chesterfield
Bloss, Jeffrey D.	**026**	Columbia
Blount, DeAun M.	**126**	Kansas City, KS
Blum, Carol A.	**002**	Excelsior Springs
Blum, Donald A.	**190**	St. Louis
Boatright, Kevin	**138**	Farmington
Bock, Linda P.	**190**	St. Louis
Bockelman, Whitney	**218**	Columbia
Boedeker, James P.	**190**	St. Louis
Bogart, Douglas B.	**125**	N. Kansas City
Bohigian, George M.	**190**	St. Louis
Bohl, Daniel	**222**	St. Louis
Bohn, William W.	**125**	Kansas City
Boland, Michael F.	**190**	Chesterfield
Boldizar, Albert G.	**190**	St. Louis
Boldt, Thomas H.	**190**	Bridgeton
Boles, C.R.	**190**	St. Louis
Boles, Murray	**026**	Columbia
Bolinske, Robert E.	**190**	St. Louis
Bollier, Barbara G.	**002**	Kansas City
Bonacorsi, John	**190**	Bridgeton
Bonar, Susan K.	**125**	Kansas City
Bondurant, Charles P.	**026**	Columbia
Bonebrake, Mac D.	**082**	Springfield
Bonfanti, Albert L.	**190**	Chesterfield
Bonham, Roger D.	**026**	Columbia
Boniuk, Isaac	**190**	St. Louis
Bonney, Samuel C.	**207**	Washington
Bonsanti, Robert L.	**190**	Bridgeton
Boodram, Mitra B.	**190**	Maryland Heights
Boone, Daniel C.	**050**	Gladstone
Boone, Karen E.	**189**	St. Charles
Boonshaft, Benje	**190**	St. Louis
Booth, Gregory R.	**218**	Columbia
Booth, Randall K.	**214**	Nevada
Booton, Derek V.	**125**	Kansas City
Bordy, Marvin D.	**125**	Kansas City
Borello, Dan J.	**102**	Joplin
Borkon, A. Michael	**125**	Kansas City
Borowsky, Benjamin A.	**190**	St. Louis
Botney, Kathryn	**190**	St. Louis
Botwin, Arnold E.	**125**	Leawood, KS
Bouhasin, John D.	**190**	St. Louis
Bourland, Mary E.	**102**	Joplin
Boutwell, Christine M.	**126**	Kansas City
Boveri, Joseph C.	**190**	St. Louis
Boveri, Lawrence V.	**002**	St. Louis
Bowe, Christopher C.	**190**	St. Louis
Bowe, Jennifer A.	**218**	Columbia
Bowen, Stephen F., Jr.	**190**	St. Louis
Bowenschulte, Bradley A.	**082**	Springfield
Bower, James S.	**125**	Kansas City
Bowers, James E.	**190**	Kirkwood
Bowles, G.R.	**190**	St. Louis
Bowles, Richard P.	**050**	Liberty
Bowman, W. Kirk	**042**	Cape Girardeau
Bowser, Robert L.	**050**	Independence
Boyarsky, Saul	**190**	St. Louis
Boyd, Craig W.	**190**	St. Louis
Boyd, James H.	**190**	St. Louis
Boydston, Catherine O.	**118**	Odessa
Boydston, Wyatt W.	**118**	Odessa
Boylan, Peter C.	**125**	Kansas City
Boyle, Heather K.	**216**	Brentwood
Boyles, Cara	**222**	St. Louis
Brabbee, Gregory W.	**190**	St. Louis
Brabson, John H.	**082**	Springfield
Bradbury, George R., III	**190**	Bridgeton
Braddock, Stephen	**026**	Columbia
Bradford, John F.	**125**	Shawnee Mission, KS
Bradley, Richard V.	**190**	St. Louis
Bradshaw, William D.	**125**	Belton
Brady, Harry R.	**190**	St. Louis
Brady, Hugh S.	**118**	Concordia
Brady, Timothy T.	**190**	St. Louis
Branch, Walter D., Jr.	**002**	Kansas City
Branham, Gregory H.	**190**	St. Louis
Braun, Alan L.	**058**	Jefferson City
Braun, Donald N.	**126**	Lee's Summit
Braverman, Stuart J.	**178**	Sedalia
Braxton, Frank W.	**042**	Cape Girardeau
Brazil, Maria J.	**002**	Pacific
Brazos, John C.	**178**	Sedalia
Breckenridge, Robert L.	**050**	Kansas City
Breeding, Lyle G.	**026**	Columbia
Bregant, Robert E.	**058**	Jefferson City
Brehm, G. Scott	**102**	Joplin
Breite, Warren M.	**106**	Festus
Brennan, George A.	**190**	St. Louis
Brennan, James M.	**190**	St. Louis
Brennan, Richard X.	**190**	St. Louis
Brennan, Robert A., Jr.	**190**	St. Louis
Brennan, Robert A., Sr.	**190**	St. Louis
Brennan, Robert V.	**190**	St. Louis
Brent, Jeffrey F.	**222**	Brentwood

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Brent, Lanny R.	Springfield	082
Bresnahan, Dennis R.	Kansas City	125
Brewer, Joseph H.	Kansas City	125
Brewster, Luke	St. Louis	216
Brian, William J.	Springfield	082
Bricker, Eugene M.	St. Louis	190
Bridges, J. Rachelle	Forsyth	208
Bridges, Jack L.	St. Joseph	030
Bridges, Leonard W.	Forsyth	208
Bridges, Matthew A.	Kansas City, KS	220
Brigden, Robert B.	Neosho	102
Briggs, Thomas B.	Springfield	082
Brigham, David W.	Ballwin	190
Bright, James E.	Springfield	082
Brink, David S.	St. Louis	195
Brischetto, Michael J.	St. Louis	190
Britton, Loretta M.	Kansas City	125
Broaddus, Loren E.	Springfield	082
Brock, Arthur L.	Independence	125
Brockhaus, Jayne R.	Warrensburg	110
Brockman, Jennifer E.	Columbia	218
Brockman, M. Douglas	Springfield	082
Brodeur, Armand E.	St. Louis	190
Brodkey, Mark J.	Kansas City	125
Brody, Arnold G.	St. Louis	190
Brog, Michael A.	St. Louis	190
***Bronson, Wendell D.**	St. Joseph	030
Brook, Charles J.	Kansas City	125
Brookes, Robert D.	Chesterfield	190
Brookings, Marla K.	Kansas City	218
Brooks, Christy	St. Louis	216
Broughton, Alicia	Kansas City	220
Brown, Barry D.	St. Louis	190
Brown, Cynthia L.	Poplar Bluff	034
Brown, David L.	Osage Beach	120
Brown, David M.	St. Louis	190
Brown, Elwyn S.	Kansas City	125
Brown, Frederick B.	Aurora	166
Brown, Freeman F., III	Ballwin	190
Brown, Julie E.	Mission, KS	220
Brown, Katherine E.	Kansas City	224
Brown, Merlin D.	St. Joseph	030
Brown, Mike J.	Cape Girardeau	042
Brown, Norbert W.	Kansas City	125
Brown, Randy G.	Kansas City	125
Brown, Rebecca L.	Springfield	082
Brown, Robert J.	St. Charles	189
Brown, Robert S.	Shawnee Mission, KS	125
Brown, Seymour	Chesterfield	190
Brown, Ty D.	St. Louis	222
Brownsworth, Ronnie D.	Springfield	082
Bruce, Leo A.	Sikeston	202
Bruce, Robert P.	Kansas City	125
Bruggeman, Jerry	Columbia	218
Brukardt, Diane T.	Columbia	026
Brumfield, Amy S.	Murray, KY	126
Bruno, Patrick L.	Granite City, IL	002
Bruns, Kenneth	St. Louis	190
Brunworth, David	Washington	207
Bruton, Ronald	Springfield	085
Bryant, Lester R.	Asheville, NC	026
Bryer, Mark P.	Columbia	026
Buchanan, Barbara N.	Belton	125
Buchele, Alan Morrow	Joplin	102
Buchele, Sheila Marie	Joplin	102
Buchert, Peter K.	Columbia	026
Buchinger, Colleen L.	Kansas City	126
Bucholz, Richard D.	St. Louis	190
Buchwach, Kenneth A.	Independence	125
Buckner, John W.	Springfield	082
Buckner, Robert C.	Shawnee Mission, KS	125
Bucol, Kevin D.	St. Louis	190
Budd, John J., Jr.	St. Louis	190
Buehler, Carl T., Jr.	Eldon	120
Buettner, John Brigham	Chesterfield	190
Buffaloe, Robert N.	Jefferson City	058
Buie, Bruce R.	Kansas City	125
Buie, Steven E.	Kansas City	125
Bukstein, Michael J.	Hannibal	150
Bult, Mark J.	Springfield	082
Bultman, Laura L.	Columbia	218
Bumgarner, James E.	Columbia	026
Bumgarner, Roger W.	Columbia	026
Bunge, Nancy J.	Mexico	014
Burch, John E.	Naples, FL	102
Burcham, Tom R.	Farmington	042
Burdin, Julie L.	Columbia	218
Burfeind, Rebecca C.	Overland Park, KS	126
Burgdorf, Max H.	Bridgeton	190
Burgess, Dean	St. Louis	190
Burk, Emmett K.	Plano, TX	050
Burke, James S., Jr.	St. Louis	190
Burkey, Jordan W.	Springfield	082
Burkhart, Edward F.	Delray Beach, FL	190
Burkhart, Susan M.	California	058
Burks, Michael L.	Columbia	026
Burleigh, Bruce W.	Joplin	102
***Burns, Bernard C., III**	Cape Girardeau	042
Burns, Edward L.	St. Louis	190
Burns, Francis J.	St. Louis	190
Burns, Michael F.	St. Louis	190
Burns, Thomas W.	Columbia	026
Burroughs, Nathan D.	N. Kansas City	050
Burry, Virgil F.	Blue Springs	125
Burst, Donald O.	Key Largo, FL	190
Burstein, Robert	St. Louis	190
Burton, Curtis D.	Hannibal	150
Busby, Leslie T.	Mission, KS	126
Buse, Paul E.	St. Louis	190
Bush, William M.	Imperial	218
Bush-Smith, Kimberly A.	St. Louis	216
Busiek, Paul J.	Springfield	082
Buss, Mary I.	Lee's Summit	220
Busse, Paul P.	St. Louis	190
Bussmann, Carl E.	Bridgeton	190
Bussmann, Donald W.	Chesterfield	190
Bussmann, Yvonne L.	Springfield	082
Butin, Richard E.	Kansas City	125
Butler, Elza F.	St. Joseph	030
Butsch, Richard H.	St. Louis	190
Butterfield, Mari Anne	Lee's Summit	125
Byars, Steven R.	Kansas City	125
Byers, Lowell J.	Leawood, KS	125
Byersdorfer, Craig A.	St. Louis	222
***Bynum, Carl G.**	Jefferson City	058
***Bynum, Robert L.**	Columbia	026
***Byrne, Kevin G.**	Osage Beach	120
Byrum, Fritz A.	Wildwood	190

C

Cabanas, Justo J.	Shawnee Mission, KS	125
Cabbabe, Edmond B.	St. Louis	190
Cabbabe, Samer W.	St. Louis	216
Cabral, G.	Florissant	190
Cabrera, Tomas V.	St. Peters	189
Cacioppo, Joseph E.	St. Louis	190
Cadiz, Briccio S., III	Ste. Genevieve	174

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Cady, Roger K.	082	Springfield
Caffrey, Raymond J.	125	Independence
Cain, Alvin R.	018	Lamar
Caldwell, Joseph L.	082	Springfield
Calhoun, Joshua W.	190	St. Louis
Call, Conley B.	216	St. Louis
Callaghan, Gerard M.	190	St. Louis
Callahan, Joseph D.	190	St. Louis
Callaway, Guy D., Jr.	082	Springfield
Callaway, Jo J.	002	Kansas City
Callaway, Lawrence A.	125	Kansas City
Callicoat, Paul E., Jr.	102	Joplin
Calodney, Martin M.	190	St. Louis
Calovich, Emery R.	125	Shawnee Mission, KS
Calvert, George T.	222	Louisville, KY
Camarata, Paul J.	125	Kansas City
Camejo, Manuel	082	Springfield
Cameron, Jeffrey W.	125	Kansas City
***Cameron, Roger W.**	058	Jefferson City
Camp, Alan D.	002	St. Louis
Campbell, Albert J.	178	Sedalia
Campbell, Daniel C.	166	Ashland, OR
Campbell, David C.	190	St. Louis
Campbell, Edward D.	042	Cape Girardeau
Campbell, J. William	190	St. Louis
Campbell, James E.	046	Macon
Campbell, Samuel J.	050	N. Kansas City
Campbell, William S., Jr.	042	Cape Girardeau
Campos, Francisco J.	190	St. Louis
Canaan, Samuel A., Jr.	190	St. Louis
Canent, Ramon V.	125	Kansas City
Canizares, Maria J.	218	Columbia
Cannon, Jenifer M.	190	St. Louis
Cannon, Richard E.	189	St. Charles
Cannon, Sara M.	216	St. Louis
Cano-DeBelen, Grace	150	Canton
Cantor, Harvey E.	190	St. Louis
Caplin, David A.	190	St. Louis
Caputo, Cynthia J.	125	Raytown
Cara, Elma E.	002	St. Louis
Carden, Juan O.	190	St. Louis
Cardwell, Daniel R.	066	Bolivar
Carey, Larry J.	082	Springfield
Cargill-Hickman, Dianna	050	Liberty
Carleton, Charles E.	138	Farmington
Carlin, M. Richard	190	St. Louis
Carls, Garry L.	190	Imperial
Carlson, John V.	014	Mexico
Carlton, Lynn N.	082	Springfield
Carmichael, Joseph C.	218	Columbia
Carmichael, Kim A.	190	St. Louis
Carmody, John P.	190	St. Louis
Carnes, Victor M.	102	Durham, NC
Carney, Stephen E.	202	Sikeston
Carolla, Robert L.	082	Springfield
Carpenter, David W.	216	Fenton
Carpenter, George T.	030	St. Joseph
Carpenter, James L.	189	St. Peters
Carpenter, Wallace	158	Rock Port
Carr, Phillip W.	082	Reeds Springs
Carranza, Mauro J.	190	St. Louis
Carrier, John A.	190	Ballwin
Carrington, Howard W.	115	Lebanon
Carroll, Thomas W.	018	Lamar
Carter, Dale M.	082	Springfield
Carter, James E., Jr.	125	Leawood, KS
Carter, James R.	166	Neosho
Carter, Robert L.	102	Joplin
Caruso, A. Cosmo	125	Kansas City
Caruso, Alfred A.	125	Kansas City
Caruso, Peter J.	125	Kansas City
Cary, John M.	190	Chesterfield
Case, Mary E.	190	St. Louis
Case, William F.	125	Kansas City
Casement, Brian A.	125	Kansas City
Casey, Arthur L.	190	St. Louis
Casey, Eliot C.	190	St. Louis
Cashman, John W.	125	Shawnee Mission, KS
Cason, Elbert H.	190	St. Louis
Cassat, James D.	207	Washington
Castaneda, Marco A.	190	Bridgeton
Caster, John P.	115	Lebanon
Caster, Philip W.	115	Lebanon
***Castle, Nial K.**	126	Shawnee, KS
Cates, Joe A.	125	Kansas City
Cathcart, David L.	120	Camdenton
Catron, David O.	042	Cape Girardeau
Caughron, Michael R.	125	Kansas City
Cavins, Theresa A.	195	Arnold
Centner, Paul J.	125	Prairie Village, KS
Cento, Donald P.	202	Sikeston
Cernik, Christine C.	190	Chesterfield
Cerullo, Michael A.	216	St. Louis
Chaffin, Jerald D.	208	Branson
Chalk, David E.	207	Washington
Chalkley, Judson I.	026	Columbia
Champion, Gretchen	222	St. Louis
Chan, Celia L.	042	Cape Girardeau
Chan, Jennifer W.	216	St. Louis
Chan, Stanley	222	St. Louis
Chandler, R. Allen	125	Kansas City
***Chandra, Ram**	118	Higginsville
Chandra, Ritik	222	St. Louis
Chandramohan, Nanjappa	102	Carthage
Chang, Caroline M.	002	Kansas City
Chang, Chil K.	026	Columbia
Chang, Robert	220	Mission, KS
Chang, Shirley M.	126	Kansas City, KS
Chanvitayapongs, Jiravud	216	St. Louis
Chanvitayapongs, Songsiri	218	Columbia
Chapman, James B.	042	Cape Girardeau
Chapman, Jean A.	042	Cape Girardeau
Chapman, Teresa	222	St. Louis
Charapata, Steven G.	125	Kansas City
Charnas, Raymond M.	190	St. Louis
Chartrand, Daniel J.	216	St. Louis
Chase, Larry K.	082	Springfield
Chase, Ned B.	102	Joplin
Chase, Peter J.	216	St. Louis
Chastain, Charles W.	138	Bonne Terre
Chavez, Salvador	190	St. Louis
Cheek, Charles W.	026	Rocheport
Chehval, Michael J.	190	St. Louis
Chen, Chang-Hao D.	216	St. Louis
Chen, Flora	216	Cupertino, CA
Chen, Joseph	222	St. Louis
Chen, Michael	218	Columbia
Chen, Ting-Hsu	222	St. Louis

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*Doctor of Osteopathy

Cheng, Caroline J.	220	Kansas City
Cheng, Shan	222	St. Louis
Cheng, Tammy P.	222	St. Louis
Cheong, Monica	222	St. Louis
Chern, Mou S.	206	Ava
Chesney, George W.	102	Joplin
Chesney, John W.	102	Joplin
Cheung, Gilbert	222	St. Louis
Cheung, K. Charles	042	Cape Girardeau
Chi, Tien-Hsin	222	St. Louis
Chicoine, Michael R.	190	St. Louis
Chien, David W.	190	St. Louis
Chilton, Jonathan D.	125	Kansas City
Chinsky, Murray	190	St. Louis
Chipongian, Raul A.	190	St. Louis
Chirino, Octavio R.	190	St. Louis
Chishti, M. Ishaq	190	St. Louis
Chiu, Johnson Y.	216	St. Louis
Cho, Kyu S.	190	St. Louis
Chod, Ronald J.	190	St. Louis
Choi, Dennis W.	190	St. Louis
Choi, Sei Young	189	St. Charles
Chong, Wincha	222	St. Louis
Chopra, Ashish	216	Brentwood
Chou, Arthur	218	Columbia
Chou, Jennifer	216	St. Louis
Chouinard, Michael P.	202	Sikeston
Choulakian, Armen	220	Mission, KS
Christ, Martin H.	030	St. Joseph
Christiansen, Sidney G.	030	St. Joseph
Christiansen, Stephen D.	082	Springfield
Christianson, Charles S.	166	Mt. Vernon
Christy, John P.	034	Poplar Bluff
Christy, Raymond A.	082	Springfield
Chu, Fred C.	190	Chesterfield
Chu, Peter Y.	125	Kansas City
Chun, Duck Sung	190	St. Louis
Chunduri, Krishna R.	190	St. Louis
Chung, T. David	034	Poplar Bluff
Churchill, Robert J.	026	Columbia
Ciapciak, Stanley J.	190	St. Louis
Cichalewski, Lisa	216	Shelbyville, IL
***Ciliberti, John A.**	050	Kansas City
Cirocco, William C.	125	Shawnee Mission, KS
Citardi, Martin J.	002	St. Louis
Clark, Alan D.	002	Springfield
Clark, David P.	026	Columbia
Clark, Granville E.	125	Kansas City
Clark, Jennifer L.	026	Columbia
Clark, Larry K.	102	Joplin
Clark, Lin Wu	125	Independence
Clarke, Michael S.	082	Springfield
Clarke, Paul W.	042	Cape Girardeau
Clarkston, Kendell C.	126	Kansas City
Clary, Randall A.	002	St. Louis
Claseman, Wilma W.	190	St. Louis
Clawson, James W.	082	Springfield
Clayton, Edgar L.	082	Springfield
Clayton, William L., III	135	Duke
Clement, Donald J.	125	Kansas City
Clever, Henry W.	189	St. Charles
Clever, Victor G.	189	St. Charles
Cline, Merle A.	125	Kansas City
Cloran, Francis J.	222	St. Louis
Clothiaux, Pierre L.	082	Springfield
Clothier, Robert W.	002	Independence
Clouse, John W.	082	Springfield
Coates, James G.	002	St. Louis
Cobb, Milton L.	190	St. Louis
Cochran, Calvin D.	125	Kansas City
Cochran, Christopher D.	126	Kansas City
Cochran, David S.	082	Springfield
Cochran, Thomas E.	082	Springfield
Cockerell, Charles F.	125	Blue Springs
Cockerell, Sanford F.	125	Independence
Cockrell, Steven N.	150	Hannibal
Codd, John E.	190	Bridgeton
Coe, Douglas A.	002	Kansas City
Coe, Jennie M.	218	Holts Summit
Coffin, Helen K.	125	Shawnee Mission, KS
***Coffman, Avon C.**	125	Kansas City
***Cohen, Donald L.**	125	Overland Park, KS
Cohen, Edward	190	St. Louis
Cohen, Harry B.	014	Columbia
Cohen, Hillard K.	190	St. Ann
Cohen, Max M.	190	St. Louis
Coin, Richard E.	190	St. Louis
Cokingtin, Cliff	125	Overland Park, KS
Cokingtin, Diana L.	125	Kansas City
Cokingtin, Leovigildo C.	125	Independence
Colapinto, Edward V.	026	Columbia
Cole, Donald E.	066	Columbia
Cole, Harry O.	190	Chesterfield
Cole, Sherman W.	125	Kansas City
Cole, William R.	178	Sedalia
Coleman, Kevin A.	190	St. Louis
Coleman, Terrence W.	125	Liberty
Colglazier, Mary C.	125	Lee's Summit
Collins, John J., III	216	Richmond Hghts
Collins, John W., Jr.	125	Independence
Collins, Samuel B.	026	Wrightsvill Bch, NC
Collison, R. Michael	082	Strafford
Colom, George A.	125	Kansas City
Colwill, Jack M.	026	Columbia
Comas, Manuel R.	190	Dunnellon, FL
Comfort, George D.	014	Mexico
Commerford, John F.	189	St. Charles
Compton, Johnathan M.	218	Columbia
Conant, James F.	030	St. Joseph
Conger, Susan C.	190	St. Louis
Conley, Brian S.	058	Jefferson City
Conn, Robert D.	125	Kansas City
Convery, Paul B.	190	St. Louis
Conway, Robert R.	026	Columbia
Cook, James R.	082	Springfield
Cook, Katherine S.	135	Rolla
Cook, Marvin A.	190	St. Louis
Cook, Paul R.	026	Columbia
Cook, Thomas B.	118	Richmond
Cooksey, Jon D.	190	St. Louis
Coonce, D. Curtis	042	Cape Girardeau
Cooper, Barry J.	190	St. Louis
Cooper, Barry R.	050	N. Kansas City
Cooper, Gary D.	050	Liberty
***Cooper, Glen E.**	026	Columbia
Cooper, Robert L., II	110	Warrensburg
Cooper, Thomas J.	190	Farmington
Cooper, V. Kent	125	Kansas City

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*Doctor of Osteopathy

Coordes, Cordie C.	190	Chesterfield
Coordes, Kathleen M.	190	St. Louis
Cope, James C.	026	Sanibel, FL
Copeland, Jeffrey G.	189	St. Peters
Copeland, Jessie L., Jr.	126	Kansas City
Copp, Ralph	190	Tucson, AZ
Coppinger, Thomas A.	125	Kansas City
Corcoran, Francis H.	102	Joplin
Cordell, Larry D.	125	Kansas City
Corder, James C.	190	St. Louis
Corder, Patricia G.	190	St. Louis
Corder, Robert L.	030	St. Joseph
Cornella, Frank A.	082	Springfield
Cornwell, Karen R.	125	Kansas City
Corrado, Joseph A.	014	Mexico
Corry, Francis M.	082	Springfield
Corry, Janice	218	Iowa City, IA
Cort, David H.	190	St. Louis
Cortner, Mary C.	125	Kansas City
Corvalan, Juan C.	190	St. Louis
Corwin, Kenneth D.	190	St. Louis
*Corzine, John J.	030	St. Joseph
Costaldi, Mark E.	216	St. Louis
Costello, John B.	190	St. Louis
Costello, Kristen M.	218	Columbia
Costen, William S.	190	Chesterfield
Costin, Jimmy L.	034	Poplar Bluff
Cotton, Thomas R.	125	Shawnee, KS
Couchman, Ryan W.	190	St. Louis
Couper, Nicholas B.	026	Columbia
Cova, Reno R.	042	Advance
Covert, Richard A.	190	St. Louis
Cowden, John W.	026	Columbia
Cox, Curtis S.	058	Jefferson City
Cox, Jeffrey L.	102	Joplin
Cox, John P.	030	Amazonia
Cox, Kurtis S.	102	Joplin
Coxe, William S.	190	St. Louis
Coyne, Patrick M.	190	St. Louis
Cozad, Scott C.	002	Kansas City
Cozean, Charles H.	042	Cape Girardeau
Cradock, Thomas V.	190	St. Louis
Crafts, David	190	St. Louis
Craig, Alan G.	190	St. Louis
Craig, Richard O.	030	St. Joseph
Craig, Robert D.	002	St. Louis
Craighead, Michael L.	058	Jefferson City
Cram, John W.	208	Branson
Cramer, Quentin	125	Kansas City
Crandall, Richard E.	190	Chesterfield
Crane, James P.	190	St. Louis
Crane, John B.	207	Washington
*Crane, William G.	030	St. Joseph
Cravens, David D.	026	Columbia
Cravens, William P.	038	Fulton
Craver, Jeffrey L.	190	St. Louis
Crawley, Jennifer H.	125	Kansas City
Crecelius, Alicia R.	216	Del Mar, CA
Crepps, Louis F.	190	St. Louis
Crespin, Stephen R.	190	St. Louis
Crespo, Horacio T.	207	Warrenton
Crespo, Remedios R.	207	Warrenton
Creswell, Lawrence L.	190	Chesterfield
Criscione, James R., Jr.	190	St. Louis
Criscione, James R., Sr.	190	St. Louis
Criscione, James S.	190	St. Louis
Critchlow, J. Thomas	042	Cape Girardeau
Critchlow, Michael E.	042	Cape Girardeau
Crockett, James E.	125	Kansas City
Croll, Gregory H.	026	Columbia
Cronbach, Emily	222	St. Louis
Cronemeyer, Richard L.	125	Lee's Summit
Crooks, Carol Y.	220	Kansas City
Crosby, William H.	102	Joplin
Crosnoe, Janna R.	042	Cape Girardeau
Cross, Lana A.	218	Columbia
Crotty, John P.	190	St. Louis
Crouch, John A.	026	Columbia
Croughan, Jack L.	190	St. Louis
Crow, Brad	216	St. Louis
Crow, Martin L.	125	Kansas City
*Crow, Sam A., II	082	Springfield
*Crowell, Tamara E.	125	Lee's Summit
Crowley, William J.	026	Spicewood, TX
Croy, David W.	102	Joplin
Crumpacker, Margaret	190	St. Louis
Crumpacker, Rex K.	102	Joplin
Cruz, Sergio G.	166	Monett
Cryer, Philip E.	190	St. Louis
Cuddihee, Robert E.	190	St. Louis
Culver, Perry J., Jr.	125	Kansas City
Cummings, Clayton	218	Columbia
Cummings, Kenneth	222	St. Louis
Cummings, Kenneth C.	125	Kansas City
Cummings, Steven W.	190	Brentwood
Cunningham, D. Dean	082	Springfield
Cunningham, Edwin J.	190	Chesterfield
Cunningham, Milamari A.	026	Columbia
Cunningham, R.Raymond	026	Columbia
Cunningham, William F.	082	Springfield
Cupp, Gerald V.	026	Columbia
Cupp, Michael R.	026	Columbia
Curnow, Richard B.	050	Liberty
Curry, Michael D.	026	Columbia
Curry, Michael J	189	St. Charles
Curtis, Brian M.	126	Kansas City
Curtis, Jack J.	026	Columbia
Cusumano, Joseph V.	190	St. Louis
Cusworth, Robert	189	St. Charles
Cyriac, George K.	014	Mexico
Czebrinski, Edward W.	190	Chesterfield

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Daake, John W., Jr.	190	St. Louis
Daake, John W., Sr.	190	St. Louis
Dabbs, Wilbur D.	166	Neosho
Dacey, Ralph G., Jr.	190	St. Louis
Dagartzikas, A. K.	190	St. Louis
Dahm, Charles H., Jr.	190	St. Louis
Dahm, John D.	190	St. Louis
Daily, James M.	082	Springfield
Dalton, Timothy T.	125	Kansas City
*Daly, Michael M.	026	Columbia
Dames, Richard J.	190	Chesterfield
Dandridge, Walter C.	102	Joplin
Danforth, William H.	190	St. Louis
Dang, Robert C.	214	Pleasant Hill
D'Angelo, James A.	125	Blue Springs
Daniel, A.E.	026	Columbia

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*Doctor of Osteopathy

Daniel, William C.	125	Kansas City
Daniels, John S.	002	St. Louis
Daniels, Shannon L.	218	Ashland
***Daniels, William B.**	125	Leawood, KS
Dankner, Rand E.	190	Chesterfield
Danner, Shavonne L.	125	Kansas City
Danuser, Carol B.	026	Columbia
Darkow, Grant V.	026	Columbia
Darnell, Dale E.	125	Kansas City
Dash, Udaya N.	190	Bonita Springs, FL
Daum, Harold F.	178	Sedalia
Daus, Arthur Steven	102	Joplin
David, Henry	218	Columbia
Davidner, Mark L.	125	Kansas City
Davidson, Morris	190	St. Louis
Davidson, Raymond P.	190	St. Louis
Davis, Carl S.	125	Lee's Summit
Davis, Charles S.	102	Galena, KS
Davis, Cynthia L.	150	Hannibal
Davis, Donald R.	125	Prairie Village, KS
Davis, Gene L.	190	Chesterfield
Davis, Herbert V.	125	Kansas City
Davis, J. Lawrence	190	Bridgeton
Davis, Jack M.	125	Kansas City
Davis, John M.	218	Columbia
Davis, John M.	125	Kansas City
Davis, Kimberly K.	125	Independence
***Davis, Larry E.**	050	N. Kansas City
Davis, Leonard L.	014	Columbia
Davis, Richard V.	150	Hannibal
Davis, Ryan M.	126	Blue Springs
Davis, Sheldon	190	Florissant
Davis, Thomas E.	207	New Haven
Davis, Thomas N.	138	West Plains
Davis, William E.	026	Columbia
Davisson, Walter F.	058	Jefferson City
Day, Brandon S.	126	Liberty
Day, Geoffrey A.	102	Joplin
Dean, Philip D.	189	Lake St. Louis
Dean, Walter E.	158	Maryville
Deckard, Shelby W.	082	Springfield
Decker, Albert I.	082	Springfield
***Deffenbaugh, Larry D.**	102	Joplin
Degler, Shawn M.	218	Columbia
Dehner, Jonathan D.	190	St. Louis
Dehner, Louis P.	190	St. Louis
Deisher, David M.	042	Cape Girardeau
Deitchler, Kristin L.	220	Kansas City, KS
Del Pizzo, Ferdinand	189	Creve Coeur
Del Rosario, Horacio O.	190	Chesterfield
Del Santo, Peter B.	026	Columbia
Del Valle, Fernando	190	Margate, FL
***Delaney, Adrain J., Jr.**	125	Kansas City
Delaney, Carolyn	222	St. Louis
Delaney, John M.	218	Columbia
Delcambre, Marie A.	125	Kansas City
Delcau, Carey M.	190	Ellisville
deLeeuw, Karel A.	082	Springfield
Deleste, Carlos J.	106	Festus
Deligeorges, John	002	Kansas City
Dell, Robert V.	150	Hannibal
Delwood, Don M.	026	Columbia
Dement, Oman E.	102	Joplin
Demmy, Todd L.	026	Columbia
Dempsey, Kenneth J.	202	Sikeston
Dempsey, Maureen E.	026	Columbia
Denk, Alan F.	190	St. Louis
Denninghoff, James C.	026	Columbia
Denninghoff, James S.	026	Columbia
Dennis, Alia M.	220	Overland Park, KS
Denny, Matthew	222	St. Louis
***Depew, Deborah A.**	207	Cedar Hill
Derrington, Kenneth L.	120	Laurie
Dettmer, Robert F.	138	Ironton
Dever, Robert L.	102	Joplin
Devine, Mark W.	050	N. Kansas City
Devineni, V. Rao	190	Bridgeton
Devins, George S.	125	Kansas City
Dew, Michelle L.	220	Kansas City
Dew, Thomas A.	190	Chesterfield
Dewald, Paul A.	190	St. Louis
Deweese, Frederick T.	190	St. Louis
Dewein, Edward G.	190	St. Louis
Dexheimer, Frank R.	026	Columbia
Dexter, Elizabeth M.	218	Columbia
Dexter, J. Kent	082	Springfield
Dexter, James D.	026	Columbia
DeBelen, Arnold Z.	150	Canton
DeBoard, James W.	190	St. Louis
DeCastro, Edna C.	078	Chillicothe
DeCastro, Fernando J.	138	Pilot Knob
DeCastro, Kristina	220	Kansas City
DeCosta, Thomas	190	St. Louis
DeCoursey, Kenneth A.	042	Cape Girardeau
DeFelice, Charles E.	042	Cape Girardeau
DeFeo, Frederick G.	125	Kansas City
DeFeo, Theodore C.	125	Kansas City
DeGenova, Gerard H.	174	Ste. Genevieve
DeGuerre, Ronald K.	190	Chesterfield
DeLine, Jim	046	Macon
***DeLucia, Joseph A.**	206	Potosi
DeMotte, Jeanne M.	118	Richmond
DePriest, Michael D.	030	St. Joseph
DeSilva, Ananda	190	Hazelwood
DeUngria, Pablo C.	190	Bridgeton
DeVera, Anson E.	190	St. Louis
DeWitt, Christine a.	218	Columbia
Dick, M. Marga	026	Ashland
Diehl, Elizabeth W.	190	St. Louis
Diemer, David P.	190	St. Louis
Diemer, Jean	042	Cape Girardeau
Diemer, Peter A.	190	St. Louis
Diemer, Thomas S.	042	Cape Girardeau
Dierberg, Dale F.	207	Chesterfield
Dierker, Harry D.	026	Columbia
Diestelhorst, James A.	190	St. Louis
Dieterich, Russell B.	189	St. Charles
Dill-Bergmann, Debra A.	190	St. Louis
Dillingham, Rebecca A.	218	Columbia
Dilworth, Jacquelyn B.	190	St. Louis
Dimayuga, Nestor G.	206	Mansfield
Dinkins, James A.	042	Cape Girardeau
Ditmore, Q. Michael	026	Columbia
Dix, Patricia M.	082	Springfield
Dixon, Druery J.	206	West Plains
Dixon, G. David	125	Kansas City
Dixon, John R.	078	Brookfield
DiFilippo, Emil A.	189	St. Charles

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*Doctor of Osteopathy

DiPasco, Donald J.	190	St. Louis
DiValerio, Richard M.	190	St. Louis
Dmytryk, Eugene T.	190	St. Louis
Doan, Laura B.	125	Raytown
Doane, John F.	125	Independence
Dobard, Dennis P., Jr.	082	Springfield
Dobmeyer, Susan M.	190	St. Louis
Dobyan, Dennis C.	030	St. Joseph
Dodge, Philip R.	190	St. Louis
Dodson, Jack M.	058	Jefferson City
Dodson, Robert W.	218	Columbia
Doerhoff, Adelia L.	058	Jefferson City
Doerhoff, Carl R.	058	Jefferson City
Doisy, Philip P.	190	St. Louis
Dolan, Patrick H.	190	St. Louis
Domann, Darrel D.	082	Springfield
Domke, Henry F.	058	Jefferson City
Donati, Robert M.	190	St. Louis
Donnell, Harold E.	106	De Soto
Donnell, Robert H.	106	Crystal City
Donovan, John F.	190	St. Louis
Dorff, Jonathan	222	St. Louis
Dorsch, Ervin H.	125	Independence
Dorsch, Stephen E.	125	Independence
Dorton, Robert K.	190	St. Louis
Dorzab, Linda L.	125	Stilwell, KS
Dorzab, William E.	125	Raytown
Doshi, Jayna K.	220	Overland Park, KS
Dotson, Lori J.	026	Boonville
Douglas, Steven L., II	202	East Prairie
Dowden, Ryan M.	220	Kansas City
Dowell, George H.	190	St. Louis
Dowell, Michael R.	126	Kansas City
Dowling, Joshua L.	190	St. Louis
Downey, Jon P.	042	Cape Girardeau
Downing, Pamela J.	026	Boonville
Downs, Daniel M.	125	Kansas City
Drake, Roy F.	125	Mission, KS
Draney, Thomas E.	125	Bella Vista, AR
*Draper, Richard E.	042	Cape Girardeau
Dreher, Richard L.	125	Leawood, KS
Drescher, Emmett B.	190	St. Louis
Dresner, Steven M.	026	Columbia
Dreyer, Carl J.	190	St. Louis
Driks, Michael R.	125	Kansas City
Driskell, Karen K.	125	Kansas City
Drisko, Robert M., II	125	Kansas City
Dritz, Jay H.	222	St. Louis
Drozda, Joseph P., Jr.	190	Chesterfield
Druck, Norman S.	190	Chesterfield
Druet, Robert L.	082	Springfield
Dubin, Sol H.	125	Independence
Duda, Ralph J., Jr.	082	Springfield
Dudik, Randall G.	135	Rolla
Duemler, Robert H.	190	Glenco
Duerksen, Joseph J.	125	Shawnee Mission, KS
Duffield, Jay C.	102	Joplin
Dugan, Gerald F.	125	Kansas City
Dumadag, Virgilio P.	190	St. Louis
Duncan, David T.	189	Wentzville
Duncan, Douglas M.	082	Springfield
Dunn, Gavin	222	St. Louis
Dunn, Robert C., Jr.	190	Washington
Dunn, Scott M.	218	Columbia
Dunshee, Robert E.	158	Maryville
Duong, Vu T.	216	St. Louis
Durel, Justin H.	190	St. Louis
Durnell, Monaford D.	125	Lee's Summit
Durr, Jon W.	190	St. Charles
Durrie, Daniel S.	125	Kansas City
DuMont, Clement C.	030	St. Joseph
DuMontier, Alan J.	190	Chesterfield
Dwyer, Frank X.	125	Prairie Village, KS
Dwyer, James G.	190	St. Louis
Dyer, Carla A.	027	Columbia
Dyer, Curtis W.	110	Warrensburg
Dyer, Dallas J.	190	St. Louis
Dyer, David S.	125	Kansas City
Dyer, Gary A.	030	St. Joseph
Dyer, Jonathan A.	027	Columbia
Dymond, John B., Jr.	120	Osage Beach
Dysart, Dorsey W., Jr.	082	Springfield

E

Eachempati, Uma R.	190	Arnold
Ealovega, Mark	222	Caton, MI
Easley, Kevin O.	190	St. Louis
Eaton, Paula	125	Kansas City
Eberle, Vincent L.	190	St. Louis
Eble, Brian K.	218	Columbia
Echols, Roderick E.	222	St. Louis
Eck, Birkle	190	St. Louis
Eck, Bryan D.	206	West Plains
Eckardt, John R.	002	St. Louis
Eckenrode, James F.	026	Columbia
Ecker, Desider B.	190	Sun City Center, FL
Eckert, Clarence T.	190	Sarasota, FL
Edelman, Adam J.	218	Columbia
Edmisten, Jack	125	Independence
Edwards, David R.	178	Kansas City
Edwards, James E.	190	St. Louis
Edwards, Theodore F.	050	Kansas City
Efstathianos, Kimon	190	Belleville, IL
Egan, Thomas F.	190	St. Louis
Egbert, Robert N.	082	Springfield
Eggers, George W., Jr.	026	Columbia
Eggleston, Harry C.	190	St. Louis
Ehlert, Tamara K.	190	St. Louis
Ehrlich, Carl F.	190	St. Louis
Eidelman, Jack R.	190	St. Louis
Eisemann, Gustave	125	Overland Park, KS
Eisenbeis, John F.	190	St. Louis
Eisenberg, Steven B.	190	Chesterfield
Eisenmann, Benj P.	207	New Haven
Ekern, H. Peter	014	Mexico
Ekunno, Josiah O.	190	St. Louis
Elcock, Devera M.	190	St. Louis
Eldenburg, Donald O.	178	Sedalia
*Eldenburg, Steven C.	178	Sedalia
Elfrink, Melanie Eden	198	Marshall
Elfrink, Roy J.	198	Marshall
Elias, David J.	125	Lake Tapawingo
Elias, Ivan J.	125	Kansas City
Eliasson, Sven G.	190	Pasadena, CA
*Ellefsen, Brian K.	102	Carthage
Eller, Gordon W.	042	Cape Girardeau
Ellfeldt, Howard J.	125	Kansas City
Elliott, Raymond G.	125	Shawnee Mission, KS
Elliott, Timothy H.	126	Kansas City

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Elliott, Wendell H.	034	Poplar Bluff
Ellis, Francis J.	082	Springfield
Ellis, Harry L.	082	Springfield
Ellis, Jean H.	125	Prairie Village, KS
Ellis, John C.	125	Independence
Ellis, Katherine E.	222	St. Louis
Ellis, S. Christopher	125	Overland Park, KS
Elseby, Susan	222	St. Louis
Elser, Otto H.	125	Independence
Elwing, Terry J.	026	Columbia
Emanuel, James P.	190	St. Louis
Emeran, Georges J.	190	St. Louis
Emerson, Kimberly J.	126	Kansas City
Engelhardt, Robert C.	034	Poplar Bluff
Engelking, David F.	058	Jefferson City
Engelland, Emily	222	St. Louis
Engels, John T.	190	St. Louis
Enkvetchakul, Boonmee	082	Springfield
Enriquez, Roman S.	125	Kansas City
Eppright, Thomas D.	026	Cleveland, OH
Ernst, Edwin C., III	190	St. Louis
Ernst, Joseph G.	190	St. Louis
Ernst, Richard E.	190	St. Louis
Ervin, John E.	125	Kansas City
Esch, John G.	102	Joplin
Eschmann, Diane M.	190	St. Louis
Escoffery, Richard F.	190	Florissant
Esparrago, F. R.	166	Monett
Essman, Thomas F.	082	Springfield
Esther, John R.	102	Joplin
Esther, John W.	082	Springfield
Etienne, Robt B.	190	St. Louis
Ettelson, Charles D.	190	Chesterfield
Eubank, David F.	125	Lee's Summit
Evans, Andrew L.	002	Springfield
Evans, Jeffry T.	150	Hannibal
Evans, Joseph C., Jr.	125	Independence
Evans, Lawrence G., Jr.	190	St. Louis
Evans, Maria L.	026	Columbia
Evans, Megan D.	216	Des Peres
Evason, Kimberley J.	222	St. Louis
Evens, Ronald G.	190	St. Louis
Evenson, Juston D.	216	St. Peters
Ewing, Jill E.	218	Columbia
Exon, C.S.	058	Jefferson City
Eyen, Thomas P.	125	Overland Park, KS

F

Faber, Kevin M.	218	Columbia
Fabito, Daniel C.	190	St. Louis
Faddis, Mitchell N.	195	St. Louis
Fagan, Leonard F., Jr.	190	St. Louis
Fahrner, Mari A.	190	Chesterfield
Fair, William L.	078	Chillicothe
Fakhoury, Donald A.	050	Kansas City
Falzone, John J.	058	Jefferson City
Farberman, Elliott	190	Florissant
***Farley, Gary W.**	190	St. Louis
Farmer, Christopher D.	218	Columbia
Farmer, Norma D.	138	Farmington
Farnham, Milo M.	125	Independence
Farrar, Michael W.	125	Kansas City
***Farrell, Kevin E.**	126	Kansas City
Farrell, Sammy L.	207	Washington
Farrell, Thomas M.	002	St. Louis
Farthing, Gene W.	082	Springfield
Farwell, Wildon R.	218	Columbia
Fast, Robert E.	030	St. Joseph
Faszholz, Mark S.	190	Chesterfield
Fathman, Anthony E.	190	Chesterfield
Faulkner, C. Byron	082	Springfield
Faust, Jeffrey N.	218	Columbia
Favors, Adolphus C., Jr.	190	St. Louis
Fedotin, Michael S.	125	Kansas City
Fee, Chester F.	125	Overland Park, KS
Feliciano, Wilfrido C.	190	Maryland Heights
Felker, J. Russell	042	Cape Girardeau
Felty, Nancy A.	218	Columbia
Feng, Felix Y.	222	St. Louis
Ferguson, John F.	082	Springfield
Ferguson, John L.	082	Rogersville
Ferguson, Thomas B.	190	St. Louis
Fernandez, Fernando	030	St. Joseph
Ferneau, James E.	026	Columbia
Ferns, Francis E.	125	Kansas City
Ferrari, Herbert A.	190	St. Louis
Ferris, Charles W., Jr.	190	St. Louis
Ferris, Robert E.	058	Jefferson City
Fibuch, Eugene E.	125	Kansas City
Fichter, Christopher R.	218	Columbia
Fields, January E.	126	Gladstone
Fine, Natasha W.	216	St. Louis
Fingert, Hyman H.	190	St. Louis
Fink, Doran	222	Evanston, IL
Fink, Leroy L.	190	Florissant
Finkel, Barney W.	190	N. Ft. Myers, FL
Finnegan, Joseph V.	190	St. Louis
Fischbein, Lewis C.	190	St. Louis
Fischer, John R.	190	Hermann
Fischer, Robert	190	St. Louis
Fischer, Ronald L.	190	Chesterfield
Fisher, James K.	125	Kansas City
Fisher, Jos L.	030	St. Joseph
***Fisher, Robert B.**	026	Columbia
Fitch, Coy D.	190	St. Louis
Fitts, Bill	214	Nevada
Fitz, John R.	138	Farmington
Fivian, Gerald J.	190	St. Louis
***Flanagan, Laura M.**	126	Olathe, KS
Flance, Israel J.	190	St. Louis
Fleer, Gerald K.	189	St. Peters
Fleming, Allan R.	125	Kansas City
Fleming, David A.	026	Moberly
Fleming, J. Will, Jr.	046	Moberly
Fleming, Robert J.	189	St. Charles
Fleshman, James W.	190	St. Louis
Fletcher, Dale M.	190	St. Louis
Fletes, James W.	190	St. Louis
Florendo, Federico N.	150	Hannibal
Florendo, Purificacion T.	150	Hannibal
Flores, Jhonson E.	190	Chesterfield
Floro, Kenneth E., Jr.	190	St. Louis
Floro, Mariano N.	190	Florissant
Flotte, Sylvester A.	190	St. Louis
Floyd, Marla J.	082	Springfield
Flug, Eric J.	190	St. Louis
Flury, Kirk E.	190	St. Louis
Flynn, James M.	125	Shawnee Mission, KS
Fogarty, William M., Jr.	190	St. Louis

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Fogel, Steven T.	190	Chesterfield
Fogle, Philip R.	082	Springfield
Foley, Jonathon K.	042	Cape Girardeau
Folz, Thomas J.	058	Jefferson City
Fonseca, Peter	190	St. Louis
Foote, Daniel D.	082	Springfield
Foran, Erin	222	St. Louis
Forand, Joseph M.	190	St. Louis
Ford, Lee T.	190	Belleville, IL
Ford, Thomas E.	190	Niagara Falls, NY
Foreman, Phillip B.	150	Hannibal
Forgue, Donald R.	002	Kansas City
Forsen, James W., Jr.	190	St. Louis
Forsman, Karen E.	190	St. Louis
Forstot, Robert M.	190	St. Louis
Forsyth, B. Todd	190	St. Louis
Forsythe, Lees C.	125	Shawnee Mission, KS
Fortin, Don G.	050	Kansas City
Fortuna, Randall S.	195	St. Louis
Fortunato, Vincent P.	002	St. Louis
***Fortune, Gary J.**	002	Marthasville
Foss, Jonathan M.	190	St. Louis
Foster, R. Steve	178	Sedalia
Foster, Raymond T.	218	Columbia
Fournier, Mary E.	216	St. Louis
Fowler, Fred D.	125	Kansas City
Fowler, I. Charles	050	Kansas City
Fowler, James W.	125	Leawood, KS
Fox, Gerald E.	030	St. Joseph
Fox, Robert E.	190	Chesterfield
Fox, Thomas J.	190	St. Louis
Francel, Thomas J.	002	St. Louis
Francis, Roger A.	120	Linn Creek
Francisco, Clarence B.	125	Shawnee Mission, KS
Francisco, Dominic S.	190	St. Louis
Franey, Michelle R.	125	Kansas City
Frank, Gael R.	125	N. Kansas City
***Frank, Robert A.**	125	Independence
Fraser, Victoria J.	190	St. Louis
Frazier, Robert E.	026	Columbia
***Frederick, Mark R.**	058	Jefferson City
Frederickson, Neil W.	190	St. Louis
Freedman, Ruth S.	190	St. Louis
Freeland, Arthur G.	110	Warrensburg
Freeman, Brad	190	St. Louis
Freeman, James A.	026	Columbia
***Freeman, Steven P.**	126	Roeland Park, KS
Freer, James M.	218	Columbia
Freer, Phoebe E.	222	St. Louis
Freilich, Brad	125	Overland Park, KS
Frein, Donald E.	214	Harrisonville
French, Amber C.	226	Cape Girardeau
Frevert, Larry F.	125	Kansas City
Frey, Jeffrey P.	026	Columbia
Friedman, Ira J.	207	Washington
Friedman, Michael J.	026	Columbia
Friedman, Morris L.	125	Shawnee Mission, KS
Friedman, Robert H.	190	St. Louis
Friedman, William H.	190	St. Louis
Friesen, Randall G.	189	St. Charles
Fritsch, Andrew J.	102	Joplin
Fritzlen, Thomas J.	125	Overland Park, KS
Froehlich, Thomas W.	082	Springfield
Frogge, Jim D.	102	Joplin
Frohman, Boris	202	Sikeston
Fromme, Glenn A.	082	Springfield
Frumson, Guy H.	190	Florissant
Fryer, Dorothy S.	190	St. Louis
Fu, Anna L.	190	St. Louis
Fu, Cary	218	Columbia
Fuchs, George J.	026	Lake Ozark
Fuhrman, Donald L.	125	Leawood, KS
Funsch, Robert E.	190	St. Louis
Fusselman, Jon M.	082	Springfield

G

Gabbay, Mojan	216	Brentwood
Gabel, Michael G.	190	St. Louis
Gafarian, Kathleen	082	Springfield
Gafford, Franklin H., IV	190	St. Louis
Gailey, Raymond K.	102	Joplin
Gaines, Robert W.	026	Columbia
Gainor, Barry J.	026	Columbia
Gaitonde, Mangesh R.	026	Lee's Summit
Galakatos, Andrew E.	190	St. Louis
Galakatos, Gregory R.	190	St. Louis
Galate, Joseph F.	125	Kansas City
Galblum, Larry I.	125	Kansas City
Galbraith, Polly M.	125	Kansas City
***Galbraith, Timothy C.**	058	Jefferson City
Gale, Arthur H.	190	St. Louis
Gall, Clifford M.	125	Kansas City
Gall, Ira C.	190	St. Louis
Galtor, Anat	222	St. Louis
Galvez, Sisenando P.	078	Marceline
Ganninger, Maria V.	220	Mission, KS
Ganninger, Paul R.	216	Des Peres
Gans, Lawrence A.	190	Florissant
Gantz, John A.	190	St. Louis
Garbutt, Jason	216	St. Louis
Garcia, Delia M.	190	St. Louis
Garcia, Eduardo L.	190	St. Louis
Garcia, Juan C.	190	St. Louis
Garcia, Kathleen M.	190	St. Louis
Garcia-Ferrer, Eduardo A.	190	Miami, FL
Gardi, Delair	027	Columbia
Gardner, Joe A.	102	Joplin
Gardner, Joseph W.	166	Kimberling City
Garfinkel, Bernard T.	190	St. Louis
Garg, Shamila	126	Lenexa, KS
Garner, Royal S.	058	St. Petersburg, FL
Garrett, Ted E.	190	St. Louis
Garriga, Francisco J.	190	Florissant
Garrison, David L.	030	St. Joseph
Garrison, Roy F.	125	Kansas City
Garrison, Theodore W.	120	Camdenton
Garrison-Kester, Carla	082	Springfield
Garrotto, Lewis J.	026	Columbia
Garvin, Charles F.	190	St. Louis
Garwood, Sarah K.	218	Columbia
Gatchalian, Felicitas Z.	190	St. Louis
Gates, Mark L.	042	Cape Girardeau
Gauthier, Charles P.	125	Kansas City
Gavankar, Sharad S.	102	Joplin
Gavini, Srikanth	218	Columbia
Gay, John W.	026	Columbia
***Gayle, David R.**	034	Piedmont
***Gayle, Richard E.**	034	Piedmont
Gearhart, Beth J.	190	St. Louis

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*Doctor of Osteopathy

Gearhart, David L.	190	St. Louis
Gehm, Louis E.	214	Butler
Geier, David L.	082	Springfield
Geier, Larry J.	125	Kansas City
Geisse, Guillermo C.	190	St. Louis
Gelberman, Sara C.	222	St. Louis
Geller, Bruce D.	125	Leawood, KS
Gellman, Elliot F.	190	St. Louis
Gendel, Jonathan	125	Lee's Summit
Gennaoui, Jad M.	190	St. Louis
Genovese, Ann C.	014	Mexico
Gentle, Donald L.	042	Cape Girardeau
Gentry, Michael A.	082	Springfield
Gentsch, Kenneth W.	190	St. Louis
George, Achenklinju K.	206	West Plains
George, Mary Noel	218	Columbia
George, Robert W.	042	Cape Girardeau
Geraghty, Thomas E.	125	Kansas City
Gerber, Paula	222	St. Louis
German, David S.	190	St. Louis
German, Walter A.	082	Springfield
Germann, Donald R.	125	Shawnee Mission, KS
Gernstetter, S. L.	034	Poplar Bluff
Gerowin, Lance	190	St. Louis
Gessler, James A.	082	Springfield
Geter, Rodney K.	082	Springfield
Ghafoor, Nadia	218	Columbia
Ghazal-Albar, Naman	150	Louisiana
Ghiz, Adam F.	222	St. Louis
Gholkar, Vijay R.	125	Kansas City
Ghosh, Nillima N.	190	St. Louis
Giangiacomo, Annette L.	218	Columbia
Gibbons, James J.	190	St. Louis
Gibbons, Robert T., Jr.	125	Overland Park, KS
Gibbs, Scott R.	042	Cape Girardeau
Gibfried, Matthew J.	218	Columbia
Gibson, David M.	125	Santa Fe, NM
Gibson, James D.	082	Springfield
Gibson, Paul H.	190	St. Louis
Gibson, William P.	190	Chesterfield
Giddings, Frank C.	082	Springfield
Gieselmann, James W.	034	Poplar Bluff
Gilbirds, William M., II	050	Kansas City
Gill, Paul J.	082	Springfield
Gilliland, Craig	002	Kansas City
Gilula, Louis A.	190	St. Louis
Giminez, Maryann	222	St. Louis
Gimovsky, Martin L.	002	St. Louis
Gimpelson, Richard J.	190	Chesterfield
Ginsberg, B. William	125	Kansas City
Ginsberg, Fred B.	190	St. Louis
Ginther, James W., Jr.	190	St. Louis
Giocondo, Michael J.	220	Kansas City
Giorgi, Lee V.	125	Kansas City
Gipson, J. David	082	Springfield
Givler, Robert L.	125	Belton
Glaser, Dee Anna	002	St. Louis
Glaser, Larry F.	125	Cleveland
Glaser, Max	125	Kansas City
Glass, William J.	166	Nixa
Glatz, Andrew C.	222	St. Louis
Glazer, Harvey S.	190	St. Louis
Glazer, Melvin L.	125	Kansas City
Glazzard, Charles D.	082	Springfield
Glenn, Edward A., III	150	Louisiana
Glenn, Theodore J.	042	Cape Girardeau
Glenski, James A.	125	Kansas City
Glines, Michael H.	190	Arnold
Glover, David	110	Warrensburg
Gnade, Albert J.	190	St. Louis
Gnatz, Steven	026	Columbia
Godbee, Mitchell T.	218	Columbia
Godfrey, Stephen E.	190	St. Louis
Godlewski, Kris J.	125	Kansas City
Godwin, Lehman W.	082	Springfield
Goebel, Joel A.	190	St. Louis
Goeking, C. Keith	030	St. Joseph
Goel, Archna	222	St. Louis
Goff, John E.	102	Joplin
Gogel, Philip F.	216	St. Louis
Goheen, John R.	125	Kansas City
Gold, Jonathan A.	190	St. Louis
Goldberg, Joseph P.	125	Mission, KS
Golder, Robert	125	Kansas City
Goldman, Arnold M.	190	St. Louis
Goldman, Gordon M.	190	St. Louis
Goldring, James M.	190	St. Louis
Goldring, Sidney	190	St. Louis
Goldsich, Edward	125	Shawnee Mission, KS
Goldstein, David E.	026	Columbia
Goldstein, Marcy A.	002	St. Louis
Goldstein, Marvin F.	125	Kansas City
Gollier, John C.	126	Kansas City
Goltschman, John P.	190	Florissant
Gomer, Erick	218	Columbia
Gomez, Cesar A.	190	St. Louis
Gomez, Patrick L.	082	Springfield
Gondring, William H.	030	St. Joseph
Gonuguntla, Ashweena	216	Newburgh, IN
Gonzales, Jose H.	174	Perryville
Gonzalez, Alicia D.	190	St. Louis
Good, Amy B.	220	Mission, KS
Good, Michael W.	082	Springfield
Good, Thomas H.	125	Kansas City
Goodenberger, Daniel M.	190	St. Louis
Goodhope, Karen F.	190	St. Louis
Goodman, Sara E.	218	Columbia
Goodwin, J. Wendall	082	Springfield
Gordon, Bruce J.	026	Columbia
Gordon, Glenn L.	014	Mexico
Gore, Pankaj A.	222	St. Louis
Gorman, Cecilia F.	218	Columbia
Gorman, Mary Jo	190	St. Louis
Gose, Don F.	082	Springfield
Gottsch, Joseph C.	125	Shawnee Mission, KS
Gould, Ronald J.	190	St. Louis
Gowda, Manohar Sai	126	Shawnee, KS
Gowdamarajan,Rengasamy	125	Kansas City
Grable, James D.	042	Cape Girardeau
Grady, Ronald K.	190	Chesterfield
Graff, Ralph J.	190	St. Louis
Graham, Bruce D.	002	Shawnee Mission, KS
Graham, John D.	190	St. Louis
Graham, Joseph E.	190	St. Louis
Graham, Patrick G.	125	N. Kansas City
Gramates, Peggy H.	190	Florissant
Granberg, Steven J.	190	St. Louis
Grand, M. Gilbert	190	St. Louis

Grandstaff, P. Matthew	125	Prairie Village, KS
Grant, Kenneth E.	190	St. Louis
Grant, Laura L.	026	Columbia
Grant, Neville	190	Santa Fe, NM
Grant, Ruth	082	Springfield
Grant, William M.	026	Columbia
***Graven, Timothy G.**	189	St. Charles
Graviss, E. Richard	190	St. Louis
Gray, Gary J.	190	St. Louis
Grechus, John J.	138	Farmington
Greditzer, Harry G., III	190	St. Louis
Green, J. Richard	125	Independence
Green, Morton R.	190	Belleville, IL
Green, Thomas F.	125	Independence
Greene, Harry L.	150	Oro Valley, AZ
Greene, Howard G.	150	Louisiana
Greene, Walter B.	026	Columbia
Greenlaw, Cal W.	078	Chillicothe
Greenlund, Nelson C.	214	Nevada
Greer, Jason T.	218	Columbia
Gregory, Mark H.	190	St. Louis
Gregston, J. Leon	082	Springfield
Gregush, Ronald W.	222	St. Louis
Grenevicki, Lance F.	126	Kansas City
Gresick, Robert J., Jr.	190	St. Louis
Griesbaum, Robert V.	190	St. Louis
Griesemer, Bernard A.	082	Springfield
Griesemer, Julia E.	082	Springfield
Grieshop, Theodore J.	042	Cape Girardeau
Griffin, Darrell L.	138	Farmington
Griffin, Joshua K.	218	Columbia
Griffin, Kyle W.	218	Columbia
Griffin, M. E.	066	Springfield
Griffin, Shawn	030	St. Joseph
Griffin, William T.	026	Columbia
Griffith, S. Kent	042	Cape Girardeau
Griffith, Stephen P.	218	Columbia
Grillot, Michael B.	082	Springfield
Grim, Edward M.	102	Joplin
Grimes, Alan	002	N. Kansas City
Grimes, Elwyn M.	125	Kansas City
Grimm, Mark E.	082	Springfield
Grimm, Mary T.	190	Chesterfield
Grisham, Thomas D.	207	Washington
Groce, George D.	038	Fulton
Groeper, Kelly	218	Columbia
Groh, Kieth W.	218	Columbia
Groshong, Ted D.	026	Columbia
Gross, Elizabeth K.	222	St. Louis
Grossberg, George T.	190	St. Louis
Grubb, Michael M.	102	Joplin
Grubb, Robert L., Jr.	190	St. Louis
Grubenhoff, Joseph A.	216	St. Louis
Grunz, Donald J.	190	Creve Coeur
***Gryte, Rolf R.**	120	Osage Beach
Guarino, Anthony H.	190	Chesterfield
Guastello, Joseph R.	125	Kansas City
Guastello, Mario J.	125	Kansas City
Guerra, Gaston G.	125	Kansas City
Guhleman, Henry V.	058	Jefferson City
Guillory, Robin	222	St. Louis
Guinn, O. Allen, III	125	Independence
Gujarati, Subhash B.	034	Poplar Bluff
Gulick, C. Richard	190	St. Louis
Gunderson, Jeffrey K.	082	Springfield
Gunn, Jack	120	Versailles
Gunn, Richard W.	125	Kansas City
Gunn, Victoria	058	Jefferson City
Gunnoe, Robert E.	125	Kansas City
Gunter, Joe S.	030	Overland Park, KS
Gupta, Nilakshi	026	Columbia
Gupta, Sanjaya K.	216	St. Louis
Gupta, Vicram	030	St. Joseph
Gur-Lavi, Joy	222	St. Louis
Gurba, Danny M.	125	Kansas City
Gurian, Lawrence E.	082	Springfield
Gursahani, Kamal	218	Columbia
Gurucharri, Vincent P.	026	Columbia
Gutek, E. Philip	125	Kansas City
Gutierrez, Ernesto	190	Florissant
Gutknecht, Richard	125	Independence
Guy, Cynthia S.	190	St. Louis
Guy, Michelle	218	Columbia
Guyer, Emily	026	Columbia
Guyol, William B., Jr.	190	St. Louis
Guze, Samuel B.	190	St. Louis
Gwin, Edward	082	Springfield

H

Ha, Richard J.	150	Hannibal
Haake, Gregory K.	082	Springfield
Haas, Robert W.	050	Liberty
Haber, Andrew T.	218	Columbia
Habermann, James H.	102	Joplin
Habert, Edward R.	190	Chesterfield
Habib, Henry N.	120	Sterling, VA
Habibe, Alex O.	216	Fresno, CA
Hadden, Laura L.	218	Columbia
Haddock, James N.	190	St. Louis
Haddow, Alastair D.	082	Springfield
Hadland, Brandon	222	St. Louis
Hagan, John C., III	050	N. Kansas City
Hagan, Margaret E.	125	Independence
Hagan, Phillip F.	050	Liberty
Hagen, Douglas W.	125	Kansas City
Hagen, Duane Q.	190	St. Louis
Hagen, Garrett A.	190	St. Louis
Hagle, Todd	218	Columbia
Hahn, Frederick W.	125	Independence
Hahn, Steven L.	002	St. Louis
Hahn, Yoram	190	Florissant
Haight, J. Max	125	Kansas City
Haight, Randall D.	058	Jefferson City
Hailey, Rachel L.	126	Overland Park, KS
Haith, Walter F.	125	Kansas City
Hakim, Shahina	220	Mission, KS
Halberstadt, Cathanie W.	125	Kansas City
Hale, Arthur E., Jr.	208	Forsyth
Hale, Thomas H.	190	Manchester
Hall, David G., III	026	Rocheport
Hall, Durward G.	082	St. Petersburg, FL
Hall, Jennifer A.	126	Kansas City
Hall, John C.	125	Kansas City
***Hall, John P.**	042	Cape Girardeau
Hall, Kristen L.	222	St. Louis
Hall, Robert T.	125	Kansas City
Hall, Stanley G.	150	Hannibal
Hall, Terry E.	078	Bethany
Halpin, Stephen E.	150	Hannibal

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Halverson, Larry W.	Springfield	082
Ham, Kevin R.	Poplar Bluff	034
Hamburg, Eric D.	Farmington	138
Hamel, Peter C.	Hannibal	150
Hamid, Rashid S.	Marshall	198
Hamid, Zahid	Mound City	158
Hamill, Robert W.	Gulfport, FL	125
Hamilton, Eugene G.	Chesterfield	190
Hamilton, William P.	Aurora	166
Hamilton, William P.	St. Louis	190
Hamly, Frederick N.	Rolla	135
Hammerman, Marc R.	St. Louis	190
Hammond, Billy A.F.	Cape Girardeau	042
Hammond, D. Wade	St. Louis	190
Hammond, Terese C.	Columbia	218
Hampton, David A.	St. Louis	222
Hanaway, Joseph	St. Louis	190
***Hancock, Thomas J.**	Jefferson City	058
Handler, Michael R.	St. Louis	190
***Handlin, Larry R.**	Mexico	014
Hanes, Lily A.	Golden Eagle, IL	190
Haney, Jessica J.	Columbia	218
Hanks, Michael S.	Springfield	082
Hanley, Thomas P.	St. Louis	190
Hannah, Hamner, III	Kansas City	125
Hannas, Ralston R.	Tucson, AZ	125
Hans, Alexandra	Columbia	218
Hansbrough, Eugene T.	Poplar Bluff	034
Hanson, E. Jerome	Kansas City	125
Hanson, Jason M.	Valley Park	195
Hanson, Karl H.	Kansas City	125
Hanson, Morin M.	St. Louis	190
Hantz, Oscar	Florissant	190
Hardacre, Ruth A.	Kansas City	125
Hardin, William B., Jr.	Manchester	190
Harding, Clarke T.	Collinsville, IL	189
Hardy, David A.	St. Louis	190
Hardy, Guerdan	St. Louis	190
Hardy, H. Malcolm	Shawnee Mission, KS	125
Hardy, Jeffery A.	St. Louis	190
Hardy, Patrick J.	Florissant	190
Hardy, Stanton L.	Desloge	138
Harell, Alex	Denver, CO	190
Hargis, James L.	Springfield	082
Hari, Magaral S.	Joplin	102
Harless, Morris S.	Memphis, TN	125
Harmon, Abigail	St. Louis	222
Harmon, Ben C.	Springfield	082
Harms, James F.	Nevada	214
Harr, Patrick B.	Maryville	158
Harrell, Darlicia	Kansas City	126
Harris, Daniel E.	Cape Girardeau	042
Harris, Hugh G.	Springfield	082
Harris, Hugh S., Jr.	Columbia	026
Harris, Lanny W.	Kansas City	125
Harris, Louis B.	Bolivar	066
Harris, Weldon L.	Independence	002
***Harris, William D.**	Lenexa, KS	125
Harrison, Garth F.	Kansas City	125
Harrison, Thomas J., Jr.	St. Charles	189
Harrison, Winston E.	Columbia	026
Harshman, David M.	St. Louis	190
Hart, L. Wayne	Shawnee Mission, KS	125
Hart, William G., Jr.	St. Louis	190
Hart, William M., Jr.	St. Louis	190
Hartman, James M.	St. Louis	190
Hartman, Richard A.	St. Louis	190
Hartmann, Michael L.	Richmond Hghts.	002
Hartnett, Anna E.	Clayton	190
Hartnett, Thomas D.	St. Louis	190
Hartstein, Jack	Chesterfield	190
Hartwig, Frederick H.	Shawnee Mission, KS	125
Hartwig, Raymond W.	Shawnee Mission, KS	125
Harvey, Judith E.	Springfield	082
Harwell, J. Larry	St. Louis	190
Harzman, Alan	St. Louis	222
Hassan, Anisa	Joplin	102
Hassien, Joel D.	Hannibal	150
Hatfalvi, Bela I.	St. Louis	190
Hatlelid, J. Michael	St. Louis	190
Haug, Darin L.	Kansas City	224
Haulard, Marcel E.	Wright City	190
Haupt, Herbert A.	St. Louis	190
Hauser, Robert J.	Jefferson City	058
Havey, John	Columbia	026
Hawatmeh, Abraham S.	St. Louis	190
Hawatmeh, Salim I.	St. Louis	216
Hawatmeh, Sam	St. Louis	190
Hawes, Arthur S.	Springfield	082
Hawk, Bray O.	St. Louis	190
Hawley-Bowland, Carla G.	Ft. Leonard Wood	135
Hawn, Kenneth D.	Columbia	218
Haybron, David M.	Columbia	026
Haycraft, Gordon L.	Cape Girardeau	042
Hayden, Melvin R.	Camdenton	120
Hayek, Michael E.	St. Louis	190
Hayes, Cynthia S.	Columbia	218
Hayes, Kimberly W.	Lee's Summit	125
Hayes, Nancy J.	Mountain Grove	206
Haynie, William W.	Butler	214
Hazan, Joseph	Bridgeton	190
Hazen, Robert M.	Prairie Village, KS	125
Hazuka, David F.	Shawnee Mission, KS	125
H'Doubler, Charles	Mt. Vernon	082
H'Doubler, Francis T.	Springfield	082
H'Doubler, Peter B.	Springfield	082
Headrick, John A.	Lake St. Louis	190
Healy, Brian E.	Kansas City	125
Heath, Jimmy D.	East Prairie	202
Heaton, Jennifer J.	St. Louis	222
***Hechler, Mark L.**	Warrensburg	110
Hecker, Joseph E.	Poplar Bluff	034
Heeb, Max A.	Sikeston	202
Hegde, Korgi V.	St. Louis	190
Hegde, S. Roy	Kansas City	125
Heidemann, Amanda J.	Ballwin	222
Heilman, M. Kathlyne	Bolivar	066
Heimburger, Richard A.	Jefferson City	058
Heins, James N.	St. Louis	190
Heinsz, Amanda R.	Columbia	218
Heinz, George, III	Springfield	082
Heise, Julie R.	Kansas City	125
Helikson, Mary A.	Columbia	026
Hellam, Duane C.	Springfield	082
Hellebusch, Lynn M.	St. Louis	216
Heller, Randall L., Jr.	St. Louis	190
Helling, Thomas S.	Kansas City	125
Hellman, Richard	N. Kansas City	125

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Helzberg, John H.	125	Kansas City
Hembree, Kathryn A.	050	Liberty
Hennessey, Ann M.	058	Jefferson City
Henry, Clarke L.	125	Shawnee Mission, KS
Henry, Clarke L., Jr.	125	Kansas City
Henry, Joseph E.	050	Shawnee Mission, KS
Henry, Lawrence D.	058	Columbia
Henry, Mary M.	125	Kansas City
Henry, Norah L.	222	St. Louis
Henry, R. Beth	125	Kansas City
Henson, Bruce E.	125	Kansas City
Herbers, Mark F.	190	Fenton
Herfkens, Kenneth D.	082	Springfield
Herman, Karlynn D.	218	Columbia
Herman, Robert L.	125	Kansas City
Hermann, Cathy	222	St. Louis
Hermsen, Kathryn P.	216	Belleville, IL
Hernandez, Salvador R.	190	St. Louis
Herold, Robert E.	189	St. Charles
Herrick, Thomas B.	050	Kansas City
Herrmann, Deborah A.	198	Marshall
Hershey, Falls B.	190	St. Louis
Hervey, William H.	125	Kansas City
Herzog, Jacques A.	190	Chesterfield
Hesker, Albert E.	190	Chesterfield
Hess, L. Wayne	026	Columbia
Hester, Jennifer K.	126	Kansas City
Hettinger, Brenda A.	120	Camdenton
Heutel, Lee B.	190	St. Louis
Hickey, James L.	190	St. Louis
Hicks, Christina M.	038	Fulton
Hicks, Frederick G.	190	St. Louis
Hicks, Robb R., IV	042	Cape Girardeau
Hierholzer, Rebecca S.	125	N. Kansas City
Higginbotham, Dennis G.	206	West Plains
Higgins, Edward F., Jr.	125	Kansas City
Higgins, Laura A.	216	Brentwood
Higgins, Michael G.	042	Cape Girardeau
Higgins, Philip C.	190	St. Louis
Higgs, Philip E.	190	St. Louis
Highland, Thomas R.	026	Columbia
Hignight, James E.	125	Platte City
Hill, David K.	125	N. Kansas City
Hill, M. Robert	190	St. Louis
Hill, Michael L.	102	Joplin
Hill, Randy C.	082	Springfield
Hill, Ronald T.	002	Dexter
Hillard, Alan E.	026	Columbia
Hillman, Helena W.	218	Columbia
Hillman, Noah H.	218	Columbia
Hills, Joe E.	082	Springfield
Hilton, Paul E.	102	Joplin
Himes, Joyce B.	082	Springfield
Hinderks, Betty A.	218	Columbia
Hinds, R. David	026	Columbia
Hindupur, Mohan R.	030	St. Joseph
Hinrichs, Christian S.	126	Kansas City
Hinrichs, James H.	190	Bridgeton
Hinshaw, Kevin D.	190	St. Louis
Hinton, Paul A.	216	St. Louis
Hintze, Paul F.	190	St. Louis
Hironimus, John E.	190	St. Louis
Hiser, Christy J.	208	Branson
Hishaw, Georg A.	218	Columbia
Hite, Dennis E.	115	Lebanon
Ho, Dora	222	St. Louis
Ho, Judith E.	190	St. Louis
Hoberock, Thomas R.	208	Branson
Hodge, Robert H.	050	Kansas City
Hodge, Robert H., Jr.	026	Columbia
Hoech, George P., Jr.	125	Kansas City
Hoehn, John P., III	190	St. Louis
Hoeman, Michael D.	082	Springfield
Hoeper, Samuel D., Jr.	125	Kansas City
Hoeper, Samuel D., Sr.	125	Grandview
Hoffarth, Sharon C.	190	St. Louis
*Hoffman, James E.	042	Cape Girardeau
Hoffman, Leanna M.	078	St. Joseph
Hoffman, Mark J.	190	St. Louis
Hoffman, William F.	190	St. Louis
Hoffmann, Alan L.	125	Kansas City
Hoffmann, Lee M.	125	Shawnee Mission, KS
Hoffmann, Ronald E.	190	St. Louis
Hoffmann, Sandra S.	190	Chesterfield
Hofmeister, Roger W.	026	Columbia
Hofstatter, Leopold	190	St. Louis
Hogan, Cornelius E.	190	St. Louis
Hogan, John R.	190	St. Louis
*Hogan, Patricia E.	030	Maryville
Hogan, Patrick A.	190	St. Louis
Hogan, Patrick C.	190	St. Louis
Hoja, John M.	034	Poplar Bluff
Hoja, W. Alex	034	Poplar Bluff
Holand, Roy W.	082	Springfield
Holds, John B.	190	St. Louis
Holekamp, Timothy	026	Columbia
Holemon, R. Eugene	190	St. Louis
Holkins, John M.	125	Kansas City
Holland, Derek	222	St. Louis
Holley, Donald B.	082	Springfield
Hollie, Melissa L.	216	St. Louis
Hollis, Richard W.	082	Springfield
Hollocher, Richard J.	190	St. Louis
Holloman, Walter G.	190	Ballwin
Holloway, Robert B.	190	St. Louis
Holloway, Walter R.	206	West Plains
Holmes, David R.	082	Springfield
Holmes, Nancy E.	190	St. Louis
Holmes, Stephen L.	218	Columbia
Holowaty, J. Carl	190	St. Louis
Holschen, Jolie C.	222	Florissant
Holt, Janis L.	216	St. Louis
Holtmann, Barbel	190	St. Louis
Holton, Edward B.	125	Independence
Holtz, Alan S.	190	St. Louis
Holtz, Sumner	002	Chesterfield
Holzem, Craig S.	207	Washington
*Hon, Sarah Jane	050	Liberty
Honaas, Trygve O.	042	Cape Girardeau
Honeycutt, Pamela J.	026	Columbia
Hong-McAtee, Irene	222	Indianapolis, IN
Hoos, Gary L.	082	Springfield
Hooshmand, Ahmad	058	Jefferson City
Hopkins, Bobbi L.	218	Columbia
Hopkins, James P.	125	Shawnee Mission, KS
Hopkins, Thomas A.	082	Springfield
Hopson, David K.	190	St. Charles
Horacek, Jeri L.	082	Springfield

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Horan, John J., Jr. St. Louis	190
Horenstein, Simon St. Louis	190
Horn, Paul C. Cape Girardeau	042
Hornbostel, Phillip M. Sedalia	178
Horner, John L. Chesterfield	190
Hornig, Gregory W. Kansas City	125
Hornstra, Robijn K. Kansas City	125
Horton, James D. Springfield	082
Hoskins, R. Bruce Kansas City	125
Hosler, Mark W. Cape Girardeau	042
***Hosley, Brett D.** Hannibal	150
Houck, William E. Chesterfield	190
Houghton, Howard L. Kansas City	125
Houseman, Andrew St. Louis	222
Hover, Alexander R. Springfield	082
Howard, Campbell P. Kansas City	125
Howell, Billy D. Brookfield	078
Howell, Greg Kansas City	220
Howshar, Mark E. Cape Girardeau	042
Hoye, Robert C. Ste. Genevieve	174
Hrabik, Brent Tarkio	158
Hruza, George J. St. Louis	190
Hruza, Luciann L. Ladue	002
Hsu, Alice St. Louis	222
Hu, Raymond J. St. Peters	189
Huang, Jennifer St. Louis	222
Hubbard, Sally L. Springfield	082
Hubbell, George P. Osage Beach	120
Hubbell, Marius M., Jr. Kansas City	125
Huber, Kenneth C. Kansas City	125
Hubert, John W. Bridgeton	190
***Huck, Elizabeth L.** St. Louis	190

Huck, Richard F., Jr. St. Louis	190
Hucke, Samuel T., III Kansas City	125
Hudgens, Richard W. St. Louis	190
Hudgins, Marianne B. Kansas City	125
Huewe, Douglas A. Springfield	082
Huff, Kalaichelvi R. Joplin	102
Huffaker, William H. St. Louis	190
Huffman, Larry Branson W.	208
Hughes, Angela M. St. Louis	216
Hugo, Justin St. Louis	216
Hulbert, Laura R. St. Louis	190
***Hull, Jeffrey F.** Kansas City	125
Hull, Timothy A. Kansas City	125
Hulsen, Thomas M. Columbia	218
Hulstra, Johannes F. Springfield	082
Humberd, Christina M. Columbia	218
Hummel, Anton J. St. Louis	190
Hummel, Gregory L. Independence	125
Humphrey, James D. Mound City	158
Humphrey, Paul W. Columbia	026
Humphreys, Edward T. Boonville	026
Humphreys, Mitchell R. Columbia	218
Humphreys, William St. Joseph	030
Hunkeler, John D. Kansas City	125
Hunsley, Perry U. Salina, KS	208
Hunt, Darrell St. Louis	222
Hunt, Rebecca S. St. Louis	222
Hunt, Robert S. Cape Girardeau	042
***Hunter, Harlen C.** Chesterfield	190
Hunter, Heather N. St. Louis	216
Hunter, James K., Jr. Fairfax	158
Hunzicker, Kathleen A. Shawnee Mission, KS	125

Hunzicker, Warren J. Kansas City	125
Hurley, Edward J. Columbia	218
Hurley, Joseph J. St. Louis	190
Hurly, Michael P. Joplin	102
Hurst, Eva St. Louis	222
Huse, William J., II Kansas City	125
Huseman, Carol A. Overland Park, KS	002
Hussain, Muhammad Columbia	027
Husted, Frederick C. Springfield	082
Huster, Robert M. Liberty	135
Huston, Kent A. Kansas City	125
Hutchinson, James L. Springfield	085
Hutchinson, William B. St. Louis	190

I

Ibrahim, Shariq M. Columbia	218
Icaza, Ramiro Jackson	042
Ide, Carl H. Columbia	026
Idstrom, Mark E. Kansas City	125
Imholt, Kristina M. Orgeon City, OR	222
Ingram, Donald R. Festus	190
Inman, Max M. Chesterfield	190
Inniss, Rosalyn E. Kansas City	125
Ip, Aidan W. St. Louis	190
Ippensen, John H. Springfield	082
Ippolito, Joseph St. Louis	222
Ipsen, Brian Kansas City	220
Irvin, William M. St. Louis	190
Irvin, William S. Columbia	026
Isaac, Anita M. Springfield	082
***Isaacs, Victor E.** Scott City	042
Isakson, Timothy R. Columbia	218
Ishida, Yasuo St. Louis	190
Itoku, Kendall A. Chesterfield	190
Ivins, Gregory K. Fulton	038
Iwane, Akira Chesterfield	190
Izmirlian, Grant St. Louis	190

J

Jackson, Jay A. Kansas City	125
Jackson, Max G. Kansas City	125
Jackson, Vernon B. Fulton	038
Jacobs, Donald L. St. Louis	002
Jacobs, Morton Overland Park, KS	125
Jacobson, Jill D. Kansas City	125
Jaeger, Joseph N. Cape Girardeau	042
Jaggars, Marissa St. Louis	222
Jain, Savitri G. St. Louis	190
Jain, Sumer C. St. Louis	190
Jain-Roberts, Sangeeta Jefferson City	058
***James, Donald L.** Rolla	135
James, Dustin G. Victor, NY	222
James, Elizabeth J. Columbia	026
James, Kathleen M. St. Charles	189
James, Kelly M. Independence	125
James, Paul M., Jr. Fulton	038
James, Ronald C. Columbia	026
Jameson, James E. Springfield	082
Jamroz, Greg A. Washington	207
Janeczko, Gregory F. Springfield	082
Janney, Stephen K. St. Louis	190
Janssen, Margaret E. Joplin	102
Jantsch, Deborah A. Kansas City	125
Jantz, Keith Kansas City	125
Jarka, Dale E. Kansas City	125
Jarvis, Cathy C. Florissant	190

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Jassim, Omar	222	St. Louis
Javdan, Ron	190	St. Louis
Jayamanne, Damasus S.	058	Jefferson City
Jedlinski, Michael T.	042	Cape Girardeau
Jeffries, Joel T.	026	Columbia
Jenkins, Alex	218	Springfield
Jenkins, David C.	125	Kansas City
Jenkins, Edward R.	135	Laquey
Jenkins, James J.	190	St. Louis
Jennett, Richard B.	058	Jefferson City
Jensen, Joshua E., II	190	St. Louis
Jessup, Michael J.	042	Cape Girardeau
Jew, Amie C.	125	Overland Park, KS
Jiang, Jennifer C.	027	Columbia
Jimenez, David F.	026	Columbia
Jobe, Charles L.	082	Springfield
Johar, Ravi S.	190	Bridgeton
Johns, Janelle L.	218	Columbia
Johnson, C. L.	125	Kansas City, KS
Johnson, Cristen J.	218	Columbia
Johnson, Dennis L.	178	Sedalia
Johnson, Earl W.	042	Cape Girardeau
Johnson, Eric J.	002	Chesterfield
Johnson, Frank E.	002	St. Louis
Johnson, Fritz M.	082	Springfield
Johnson, Gareth R.	125	Kansas City
Johnson, Garry A.	190	St. Louis
Johnson, Glen E.	190	St. Louis
Johnson, Gordon L.	106	Crystal City
Johnson, Hillary D.	222	St. Louis
Johnson, James S.	125	Kansas City
Johnson, Joseph C., Jr.	082	Springfield
Johnson, Joseph E.	125	Kansas City
Johnson, Kevin T.	190	Bridgeton
Johnson, Lent C.	150	Hannibal
Johnson, Michelle M.	222	St. Louis
Johnson, Patrick E.	138	Farmington
Johnson, Steven M.	190	St. Louis
Johnson, Thomas M.	125	Shawnee Mission, KS
Johnson, Warford B., Sr.	082	Springfield
Johnson, Warren L., Jr.	125	Kansas City
Johnson, Zorata R.	216	St. Louis
Johnston, James M., Jr.	222	St. Louis
Johnston, Richard	190	St. Louis
Johnstone, John T.	190	St. Louis
Jolly, Ben L.	014	Mexico
Jonas, Harry S.	125	Chicago, IL
Jones, Bruce N.	190	Chesterfield
Jones, David K.	014	Mexico
Jones, Edward S.	214	Overland Park, KS
Jones, Gale O.	125	Prairie Village, KS
Jones, Georgia A.	190	St. Louis
Jones, Gordon	202	Sikeston
Jones, Harold L.	082	Springfield
Jones, Jeffrey T.	102	Joplin
Jones, Justin E.	014	Mexico
Jones, Kevin A.	026	Columbia
Jones, Laird E.	082	Springfield
Jones, Maynard C., Jr.	125	Lee's Summit
Jones, Michael D.	014	Mexico
Jones, Paul S.	102	Joplin
Jones, Randall W.	125	Independence
Jones, Rebecca M.	126	Kansas City
Jones, Richard A.	190	St. Louis
Jones, Robert P.	125	Blue Springs
Jones, Robert R.	214	Nevada
Jones, Robin R.	026	Columbia
Jones, T. Reid	125	Prairie Village, KS
Jones, Timothy R.	190	St. Louis
***Jordan, Earl L., Jr.**	102	Joplin
Jordan, Staci M.	126	Kansas City
Jorgensen, Eric D.	026	Columbia
Joseph, Daniel P.	002	St. Louis
Josephson, Scott A.	222	St. Louis
Joshi, Surekha K.	190	St. Louis
Jost, Charles A.	190	N. Fort Myers, FL
Josyula, Bhagavan V.	002	St. Louis
Jotte, Richard F.	190	St. Louis
Jotte, Richard P.	190	St. Ann
***Joubert, Paul M.**	002	Lee's Summit
Joyce, Rex M.	125	Kansas City
Judd, Corey D.	216	St. Louis
Judd, Donald R.	190	St. Louis
Judd, Jeffrey B.	190	St. Louis
Judge, Steven J.	207	Washington
Judy, Joseph D.	026	Beloit, WI
Juergens, William G.	190	St. Louis
Jung, Christopher H.	042	Cape Girardeau
Jung, J. Marshall	042	Cape Girardeau
Jung, Simon C.	050	N. Kansas City
Junker, James A.	106	St. Louis
Justesen, Scott C.	216	St. Louis
Justus, John B.	125	Shawnee Mission, KS

K

Kader, Gihan A.	190	Chesterfield
Kagan, Stuart M.	125	Kansas City
Kairuz, Bartolome C.	190	St. Louis
Kaiser, George C.	190	St. Louis
Kaiser, Scott D.	126	Kansas City
Kallenbach, Glen P.	014	Mexico
Kamakas, Nicholas C.	190	St. Louis
Kamenetzky, Stephen A.	190	St. Louis
Kanagawa, Harold K.	058	Jefferson City
Kanarek, Henry L.	125	Kansas City
Kanarek, Joseph	125	Kansas City
Kandula, Madhavi	190	St. Louis
Kane, Michael J.	034	Poplar Bluff
Kang, Glara J.	216	St. Louis
Kang, Juan	190	St. Louis
Kang, Young M.	206	West Plains
Kanne, Marty A.	050	Kansas City
Kantor, Julius M.	125	Mission Hills, KS
Kantor, Samuel	125	Englewood, CO
Kanungo, Sriraj T.	216	Chesterfield
Kaplan, Carol I.	222	St. Louis
Kaplan, Henry J.	190	St. Louis
Kaplan, Michael F.	026	Columbia
Kapp, Dave	174	Perryville
Kapp, Marybeth	042	Cape Girardeau
Kapp, William K., III	042	Cape Girardeau
Kappesser, Netajean G.	190	Utica
Kappesser, Roland C.	190	Utica
Kardesch, Milton	190	St. Louis
Karges, Melvin D.	102	Joplin
Karl, Michael M.	190	St. Louis
Karp, Elena R.	222	St. Louis
Karpilskaya, Yekaterina	222	St. Louis
***Karr, Jerry L.**	042	Cape Girardeau

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*Doctor of Osteopathy

Karraker, Alvan G.	138	Farmington
Karsh, Robert S.	190	St. Louis
Kartus, Irving	125	Shawnee Mission, KS
Kase, James B., Jr.	125	N. Kansas City
Kass, Michael A.	190	St. Louis
Kasten, Mark C.	042	Cape Girardeau
Kasten, Melvin C.	042	Cape Girardeau
Kaster, Steven D.	002	Kansas City
Katf, Nicola Y.	050	Kansas City
Katsantonis, George	190	St. Louis
Kauffman, Ruth	120	Versailles
Kaufman, Andrew B.	125	Kansas City
Kaufman, Bruce A.	190	St. Louis
Kaufman, Robert L.	190	St. Louis
Kauk, Bruce A.	050	N. Kansas City
Kaup, Chandra S.	190	Florissant
Kayanan, Jose C.	125	Kansas City
Kayes, Jack	190	St. Louis
Kays, Kenneth M.	046	Osage Beach
Kayser, Jason A.	218	Columbia
Keairnes, Harold W.	125	Kansas City
Kedora, John C.	216	St. Louis
Keefe, Catherine E.	216	St. Louis
Keefe, David M.	189	O'Fallon
Keesal, Dennis	189	Chesterfield
Kefalas, John C.	207	Washington
Keiper, Arthur S., III	026	Columbia
Keisler, Lydia W.	058	Jefferson City
Keithahn, Mari A.Z.	026	Columbia
Keithahn, Stephen T.	026	Columbia
Keller, Barbara P.	026	Columbia
Keller, Maurice J.	190	St. Louis
Keller, Stephen M.	190	St. Louis
Kellett, John G.	190	St. Louis
Kelley, Gilbert B.	010	Savannah
Kelley, Rebecca B.	038	Auxvasse
Kelly, Charles R.	125	Kansas City
Kelly, James B.	125	Kansas City
Kelly, John B.	102	Joplin
Kelly, John J.	190	St. Louis
Keltner, Raymond M., Jr.	190	St. Louis
Kendis, Joseph B.	190	St. Louis
Kenneally, Cynthia Z.	190	St. Louis
Kennedy, David G.	190	St. Louis
Kennett, Jerry D.	026	Columbia
Kenney, Douglas R.	086	Clinton
Kenney, John D.	002	St. Louis
Kenney, John D., III	125	Kansas City
Kenney, Roy E.	166	Neosho
Kensel, Scott	082	Springfield
Kenter, Keith	026	Columbia
Keohane, Mark	189	St. Charles
Kerkemeyer, George	150	Hannibal
Kerley, Spencer W.	125	Overland Park, KS
Kerr, Harold H.	125	Shalimar, FL
Kessel, James W.	190	St. Louis
***Kesseler, Randall G.**	206	Mountain Grove
***Kessler, Alan Z.**	125	Kansas City
Kessler, William D., Jr.	102	Joplin
Kester, Nathan L.	082	Springfield
Key, James S.	082	Medford, OR
Khalil, Tamer G.	082	Springfield
Khan, Abdul G.	190	Arnold
Khan, Khawla B.	002	St. Louis
Khatana, Anup K.	125	Prairie Village, KS
Khojasteh, Ali	026	Columbia
Khojasteh, Saaid	002	St. Charles
Khoury, Cecile S.	125	Leawood, KS
Khurana, Satish K.	125	Lenexa, KS
Kiburz, Douglas W.	178	Sedalia
Kichura, George M.	190	St. Louis
Kiefer, Heather E.	218	Columbia
Kies, Richard L.	042	Cape Girardeau
Kilbride, Howard W.	125	Kansas City
Kim, Chul	034	Poplar Bluff
Kim, Edy	222	St. Louis
Kim, Hee-Sun	082	Springfield
Kim, Helen Y.	222	St. Louis
Kim, Hyung S.	222	St. Louis
Kim, Paul	222	St. Louis
Kim, Stanley W.	190	St. Louis
Kim, Yang H.	207	Washington
Kim, Yong Kie	042	Cape Girardeau
Kimlinger, William R.	058	Jefferson City
Kinder, James A.	042	Cape Girardeau
Kinder, Jerry L.	042	Cape Girardeau
Kindred, Lynn H.	125	Kansas City
King, Erin	222	St. Louis
King, Francis C.	190	St. Louis
King, Frank K.	170	Hayti
King, Gregory S.	190	St. Louis
King, J. Tenbrook	125	Prairie Village, KS
King, James A.	002	Des Peres
King, John V., Jr.	190	Ballwin
King, John V., Sr.	190	St. Louis
King, M. Kenton	190	St. Louis
King, Richard H.	086	Clinton
King, Robert D.	218	Columbia
King, Tinna P.	190	St. Louis
Kingsbury, Robert J.	189	St. Peters
Kingsland, Robert C.	190	Sarasota, FL
Kinsella, Edward D.	190	St. Louis
Kinsella, Peter W.	190	St. Louis
Kinsella, Ralph A., Jr.	190	St. Louis
Kinzie, Daniel	222	St. Louis
Kipnis, David M.	190	St. Louis
Kirkland, Jerry A.	050	Kansas City
Kirsch, Jeffrey P.	190	St. Louis
Kissane, John M.	190	St. Louis
Kissell, Richard W.	082	Springfield
Kistler, W. David, Jr.	190	St. Louis
Kitchens, Daniel L.	190	St. Louis
Kitchin, Winston H.	190	St. Louis
Kiyanclar, M. Emin	190	St. Louis
Klassen, Lisa B.	222	St. Louis
Klearman, Micki	190	St. Louis
Klein, Jennifer M.	222	St. Louis
Klein, Kendel L.	166	Mt. Vernon
Klein, Sandra E.	222	St. Louis
Klein, Saul J.	190	St. Louis
Kleinschmidt, Donn C.	190	St. Louis
Klemm, J. Martin	125	Kansas City
Klenk, Alison	222	St. Louis
Kleopfer, Lynn L.	026	Columbia
Kletzker, G. Robert	190	St. Louis
Kline, Carlyn M.	030	St. Joseph
Kline, Edmund W.	030	St. Joseph
Kline, James	030	St. Joseph

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*Doctor of Osteopathy

Klinkerfuss, George H.	082	Springfield
Klippel, Allen P.	190	St. Louis
Knabb, Henry F., Jr.	082	Springfield
Knabb, Kenneth E.	082	Springfield
Knakal, Roger C.	125	Kansas City
Knapik, Dennis M.	195	Kirkwood
Knapp, Jane F.	125	Kansas City
Knight, James W.	190	St. Louis
Knight, William A., Jr.	190	St. Louis
Knipschild, Bedford F.	198	Marshall
Knoch, H. Kermit	125	Shawnee Mission, KS
Knock, Henry L.	190	St. Louis
Knop, Kevin F.	002	Liberty
Knopf, Harry L.	190	St. Louis
Knowles, R. Raymond	190	St. Louis
Knowlton, Norman P., III	082	Springfield
Knudson, Dennis R.	026	Columbia
Koch, F. Daniel	125	Kansas City
Kodner, Ira J.	190	St. Louis
Koederitz, Natalie M.	218	Columbia
Koehler, George A.	190	St. Louis
Koenig, Carolyn	216	St. Louis
Koenig, Joel S.	190	St. Louis
Koerner, Kenneth A.	190	St. Louis
Kofkoff, Richard L.	190	Bridgeton
Kohm, Mary Jane F.	002	Ladue
Koivunen, Debra G.	026	Columbia
Kolb, Jason T.	222	Brentwood
Kolb, Lisa G.	058	Jefferson City
Kolda, Michael A.	042	Cape Girardeau
Kolker, Allan E.	190	St. Louis
Kolze, Vernon W.	082	Springfield
Konijeti, Jay	220	Kansas City, KS
Koo, Michele D.	190	St. Louis
Koon, Ben H.	066	Bolivar
Koonce, John P.	058	Jefferson City
Kopelson, Jeffrey C.	190	Brewester, NY
Kopp, Shelby K.	190	St. Louis
Kopperman, Mordecai	125	Kansas City
Koppers, Lawrence E.	050	Liberty
Korba, Christine K.	207	Washington
Korenblat, Phillip E.	190	St. Louis
Korenfeld, Michael S.	207	Washington
Korn, Robert L.	190	Las Vegas, NV
Korngold, Ethan	222	St. Louis
Kosloff, Alex H.	190	St. Louis
Kosse, Karl E.	030	St. Joseph
Kotner, Lawrence M., Jr.	190	St. Louis
Kouo, Louis	042	Cape Girardeau
*Kowalski, Mark	042	Cape Girardeau
Kowert, Edward H.	190	St. Louis
Koymen, Altug	222	St. Louis
Kozminski, Mike	030	St. Joseph
Kraeger, Russell R.	190	St. Louis
Kraemer, Edwin T.	125	Lee's Summit
Kraft, Jacob	125	Palm Springs, CA
Krahn, Eve M.	050	Kansas City
Krahn, Michael J.	050	Kansas City
Kraichely, Robert	216	Hazelwood
Krain, Samuel	190	Creve Coeur
Krajcovic, David P.	190	Chesterfield
Krambeck, Amy E.	218	Fulton
Kramer, Jeffrey B.	125	Kansas City
Kramer, Robert S.	190	St. Louis
Kranson, Seymour J.	125	Wilton, CT
Kratz, Donald P.	082	Springfield
Kraus, Frederick T.	190	St. Louis
Krautmann, John J.	058	Jefferson City
Kraynack, Barry J.	002	St. Louis
Krechel, Susan W.	026	Jonesburg
Kreher, Jeffrey B.	218	Indianapolis, IN
Kreikemeier, Jeff	218	Columbia
Krejci, Elise	222	St. Louis
Krenning, Judyann	135	Rolla
Kreski, Kenneth C.	190	House Springs
Kretchmar, Alan P.	190	St. Louis
Krettek, John E.	190	Chesterfield
Kreusser, Katherine L.	190	St. Louis
Krewet, Frank A., III	190	St. Louis
Kriegshauser, James W.	190	St. Louis
Kriegshauser, Lawrence A.	190	St. Louis
Krishna, Padma	125	Shawnee Mission, KS
Kriwanek, Kelly L.	222	Manhattan Beach, CA
Kroeger, George B., Jr.	190	St. Louis
Krojanker, David N.	190	St. Louis
Krojanker, Rolf J.	190	St. Louis
Kromer, Charles J.	190	St. Louis
Kronemer, Keith A.	190	St. Louis
Kronemer, Norton S.	190	St. Louis
Kroutil, Candise D.	166	Aurora
Krug, Paul E.	125	Kansas City
Krummenacher, Thomas	190	St. Louis
Kruse, Carl R.	150	Palmyra
Kuangparichat, Manoch	118	Excelsior Springs
Kuebel, Richard J.	190	St. Louis
Kuennen, Scott H.	126	Kansas City
Kuenzi, Donald E.	050	Kansas City
Kuhn, Ann Marie	222	St. Louis
Kuhn, Lawrence F.	190	Bridgeton
Kujath, Scott W.	002	Kansas City
Kulak, Gary	190	St. Louis
Kulkarni, Nandini S.	190	St. Louis
Kumar, Varun	222	St. Louis
Kumari, Vijaya	190	St. Louis
Kunin, Audrey Gottlieb	002	Kansas City
Kunst, Edward J.	190	Manchester
Kurtz, Karl J.	125	Kansas City
Kurzweil, Steven L.	106	Festus
Kussman, Mary E.	002	St. Louis
Kuvshinoff, Boris W.	026	Columbia
Kyger, John E.	125	Independence

L

Laatsch, Robert H.	034	Poplar Bluff
Labayen, Ricardo A.	125	Overland Park, KS
Labenz, Bradley E.	218	Columbia
Lacey, Hugh L.	102	Joplin
LacKamp, Robert J.	030	St. Joseph
Ladd, Charles B.	190	St. Louis
Lai, Steve	220	Kansas City, KS
Laiben, Gregg R.	002	Kansas City
Laird, John M.	190	St. Louis
Lally, James J.	125	Kansas City
Lam, Janet C.	218	Columbia
Lam, Jonathan	222	St. Louis
Lam, Robert P.	220	Kansas City
Lamb, Michael W.	222	St. Louis
*Lambrecht, Chase T.	126	Kansas City
Lamfers, Randall B.	218	Columbia

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Lammoglia, Francisco J.	**030**	St. Joseph
Lamonte-Jost, Daniel J.	**026**	Columbia
Lampert, Benjamin A.	**082**	Springfield
Lamping, J. Daniels	**190**	Chesterfield
Lampros, William P.	**190**	St. Louis
Lampton, Lawrence M.	**026**	Columbia
Landau, David W.	**190**	St. Louis
Landau, William M.	**190**	St. Louis
Lander, Robert C.	**190**	St. Louis
Landers, Burnell	**125**	Independence
***Landers, Gary A.**	**050**	N. Kansas City
Landgraf, James R.	**125**	Independence
Landhuis, Leo R.	**026**	Rochester, NY
Landis, George K.	**125**	Raymore
Landrum, Alice L.	**026**	Columbia
Landrum, Michael L.	**218**	San Antonio, TX
Landsbaum, Charles J.	**058**	Jefferson City
Landwehr, Lawrence P.	**110**	Warrensburg
Lane, Andrew	**222**	St. Louis
Lane, Daniel K.	**190**	St. Louis
Lane, David R.	**218**	Columbia
Lang, John J.	**190**	St. Louis
Lange, David R.	**190**	Bridgeton
***Lange, John F.**	**058**	Lake Ozark
Langhammer, Carie	**218**	Columbia
Langley, Harriet S.	**125**	Kansas City
Langsdorf, Jennifer A.	**222**	St. Louis
Lankford, Harold D.	**014**	Mexico
Lapi, Angelo	**125**	Coconut Creek, FL
Larsen, David S.	**216**	St. Louis
Larsen, William E.	**125**	Shawnee Mission, KS
Larson, Kenneth W.	**082**	Springfield
Larson, Michelle	**222**	St. Louis
Laster, Jerry L.	**102**	Joplin
Laster, Steven B.	**125**	Kansas City
Latham, Raymond W.	**125**	Mission Hills, KS
Latif, Shuaib	**222**	St. Louis
Latimer, Walter N.	**050**	Kansas City
Lattinville, Henry E.	**190**	Bridgeton
Lauber, Joseph J.	**190**	St. Louis
Lauer, Danl J.	**125**	Overland Park, KS
Lauer, John D.	**190**	St. Louis
Launius, Gregory D.	**190**	St. Louis
Laux, France A.	**190**	Tucson, AZ
Lavery, Daniel P.	**058**	Westphalia
***Law, Byron D.**	**050**	Kansas City
Lawhorn, Stephanie L.	**125**	Shawnee Mission, KS
Lawson, Noel W.	**026**	Columbia
Layle, John K., Jr.	**125**	Kansas City
LaBach, James P.	**125**	Overland Park, KS
LaDriere, Raymond J.	**190**	St. Louis
LaFerriere, Keith A.	**082**	Springfield
LaFoe, William K.	**042**	Cape Girardeau
LaFrancis, Irving E.	**102**	Joplin
LaGrange, Chad	**220**	Lee's Summit
LaHue, William C.	**118**	Lexington
LaMonda, Gary W.	**026**	Columbia
LaValle, Charles E., III	**027**	Columbia
Le, Nam	**222**	St. Louis
Leach, Meredith A.	**220**	Mission, KS
***Leahy, Cindy**	**058**	Jefferson City
Leary, Daniel J., Jr.	**190**	St. Louis
Leary, Scott	**222**	St. Louis
Lederer, Charles M., Jr.	**125**	Kansas City
Lederer, Chas M., Sr.	**110**	Warrensburg
Lee, Cynthia L.	**216**	St. Louis
Lee, Darin J.	**218**	Columbia
Lee, David Y.S.	**042**	Cape Girardeau
Lee, Fransiska A.	**190**	St. Louis
Lee, Gerald B.	**214**	Kansas City
Lee, H.T.	**026**	Columbia
Lee, Henry A.	**125**	Snowmass Village, CO
Lee, Joan	**222**	St. Louis
Lee, Jung H.	**106**	Crystal City
Lee, Kevin D.	**222**	St. Louis
Lee, King Y.	**125**	Shawnee Mission, KS
Lee, Lawrence E.	**125**	Kansas City
Lee, Leander K.	**190**	St. Louis
Lee, Steven F.	**002**	St. Louis
Lee, Susan L.	**125**	Kansas City
Lee, Tae H.	**125**	Longmont, CO
Lee, Thomas K.	**190**	St. Louis
Lee, Wilfred	**042**	Cape Girardeau
Leeper, Sidlee W.	**026**	Rocheport
Legler, Larry E.	**125**	Independence
Lehman, John J., Jr.	**195**	St. Louis
Lehman, Kathy	**216**	Belleville, IL
Lehman, Richard C.	**190**	St. Louis
Lehnert, Darren L.	**082**	Springfield
Leibsohn, Joel M.	**125**	Independence
Leidenfrost, Ronald D.	**190**	Chesterfield
Leitch, Steven M.	**082**	Springfield
Lemberger, Michelle R.	**125**	Independence
Leming, Bert H., Jr.	**190**	St. Louis
Lenobel, Milton I.	**190**	Longboat Key, FL
Lents, Rickey L.	**042**	Cape Girardeau
Lentz, Harold C., Jr.	**125**	Independence
Lentz, Kathy J.	**207**	Washington
Lenzenhuber, Karl J.	**207**	Washington
Leonhardt, Erwin M.	**190**	St. Louis
Lepinski, Sandra L.	**125**	Kansas City
Lerner, Bruce	**125**	Independence
Lerner, Scott A	**125**	Kansas City
Leroux, Gene H.	**034**	Doniphan
Lerwick, Everett R.	**190**	St. Louis
Leslie, James T.	**058**	Jefferson City
Letchuman, Rama	**218**	Columbia
Letizia, Wayne L.	**125**	Independence
Levine, Laurence A.	**190**	St. Charles
Levine, Richard S.	**190**	St. Louis
Levitt, Joseph	**190**	St. Louis
Levitt, Robert G.	**190**	St. Louis
Levy, Beth K.	**190**	St. Louis
Levy, Donald S.	**189**	St. Charles
Levy, Edward S.	**002**	St. Louis
Levy, Joseph	**190**	St. Peters
Lewandowski, Molly J.	**125**	Leawood, KS
Lewin, W. Howard	**190**	St. Louis
Lewing, David C.	**125**	Independence
Lewis, J. Eugene, Jr.	**190**	St. Louis
Lewis, Lawrence M.	**190**	St. Louis
Lewis, Matthew T.	**058**	Jefferson City
Lewis, Noel R.	**082**	Springfield
Lewis, Revis C.	**125**	Kansas City
Lewis, Robert D.	**190**	St. Louis
Lewis-Lehr, Melanie M.	**218**	Columbia
Leyh, Heather S.	**224**	Kansas City
LeBlanc, Leo J.	**190**	St. Louis

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*Doctor of Osteopathy

LeFevre, Philip J.	207	Washington
Li, Renee	222	St. Louis
Liang, Jing C.	125	Independence
Libel, Roy D.	082	Springfield
Lichtor, Jos M.	125	Mission Hills, KS
Lichty, Charles A.	150	Shelbina
Lieberman, David M.	190	St. Louis
Lieberman, Scott A.	002	Bridgeton
Lien, Cindy	222	St. Louis
Lierz, Mark F.	030	St. Joseph
Lieurance, Robert K.	102	Joplin
Lifits, Yulia M.	218	Columbia
***Light, Diane L.**	058	Jefferson City
Lila, Aram	050	Excelsior Springs
***Lillig, James F.**	050	Kansas City
Lilly, Douglas R.	190	St. Louis
***Lilly, John D.**	085	Springfield
Lima, Jose A.	190	St. Louis
Limpert, Jonathan	220	Kansas City
Limpiphiphatn, Ester P.	174	Perryville
Lin, C.H.	046	Moberly
Lin, Chi-Hsi	082	Springfield
Lin, H.T.	046	Moberly
Lin, Hsiu-San	190	St. Louis
Lin, Lilie	222	St. Louis
Lin, Mary	222	St. Louis
Lin, Oscar	218	Columbia
Link, Alexander J.	190	St. Louis
Linsenmeyer, Charles M.	189	St. Charles
Lintecum, Frederick B.	125	Kansas City
Linville, Howard E.	125	Leawood, KS
Liou, Aimee	222	St. Louis
Lipoff, Jay I.	042	Cape Girardeau
Lipschitz, Ervin	190	St. Louis
Lipschitz, Eve L.	190	St. Louis
Lischwe, Daniel H.	190	Bridgeton
Liston, Michael J.	050	N. Kansas City
Littlejohn, Robert T.	050	N. Kansas City
Littleton, Stephen W.	216	St. Louis
Litton, Lyle D.	082	Springfield
Litton, Nancy J.	125	Blue Springs
Livingston, Sean	218	Columbia
Llorens, Alfred S.	026	Clemmons, NC
Lloyd, Benjamin F.	218	Columbia
Lo, Mindy	222	St. Louis
Lobati, Frederick	126	Kansas City
Lockard, Orlyn O.	030	St. Joseph
Loeb, Richard H.	082	Springfield
Loeb, Virgil, Jr.	190	St. Louis
Lofgren, Sam	222	St. Louis
Loftus, Loretta S.	125	Kansas City
Logan, William S.	125	Kansas City
Logie, Macdonald B.	190	St. Louis
***Logston, David G.**	082	Springfield
Logue, John T.	026	Columbia
Logue, William J.	042	Cape Girardeau
Lohmar, Roland E.	026	Columbia
Lohrentz, Lois H.	125	Overland Park, KS
Loitman, Bernard S.	190	St. Louis
Lomax, John E.	208	Branson
Lombardo, Joseph A.	190	St. Louis
Lombardo, Richard J.	125	Belton
Londe, Alan M.	190	St. Louis
Londe, Sol	190	Northridge, CA
London, Stanley L.	190	St. Louis
Lonergan, James H.	125	Kansas City
Lonergan, Warren M.	190	Chesterfield
Long, Curtis W.	214	Butler
Long, Denise K.	218	St. Louis
Long, Edwin T.	125	Kansas City
Long, Erin M.	222	St. Louis
Long, John W.	026	Columbia
Long, Priscilla E.	150	Hannibal
Long, R. Stacy	125	Lake Lotawana
Long, Stephen E.	082	Springfield
Long, Timothy P.	207	Marthasville
Long, W. Steven	030	St. Joseph
Lonsway, Maurice J., Jr.	190	St. Louis
Looney, Steven C.	030	St. Joseph
Lopez, Melvin M.	126	Overland Park, KS
Lopez-Plata, Roberto	125	Leawood, KS
Lord, Richard E.	190	St. Louis
Loren, Michael L.	125	Independence
Lorenc, Ernest	082	Springfield
Lorenzo, Edilberto B.	125	Poplar Bluff
Lottes, J. Otto	190	Lawrence, KS
Loughead, John R.	034	Poplar Bluff
Loutzenhiser, James K.	125	Kansas City
***Lovern, Royce E.**	207	Washington
Lovinger, Warren C., Jr.	214	Nevada
Lovinggood, Thomas A.	042	Cape Girardeau
Low, Siu Ping	222	St. Louis
Lowe, H. Arch, Jr.	082	Springfield
Lowenhaupt, Elizabeth A.	218	Columbia
Loynd, Robert C.	002	St. Louis
Luber, Kurre T.	218	Columbia
Lubniewski, Anthony J.	190	St. Louis
Luby, Maureen T.	190	St. Louis
Lucas, Thomas G.	190	St. Louis
***Lucio, John C.**	058	Jefferson City
Luckenbill, Paul T.	054	Plattsburg
Ludwig, Mark	190	St. Louis
Ludwikosky, Mike A.	125	Lee's Summit
Luechtefeld, Frank	190	Florissant
Lueckenhoff, Rebecca R.	058	Jefferson City
Luedke, Susan L.	190	St. Louis
Lueker, Stacey	218	Columbia
Luerding, Jeffrey A.	050	Kansas City
Luetje, Charles M.	125	Kansas City
Luetkemeyer, Dennis C.	027	Columbia
Luetkemeyer, James G.	058	Jefferson City
Luh, Andrew M.	190	St. Louis
Luisiri, Atchawee	190	St. Louis
Lukavsky, James P.	208	Branson
***Lumsden, Todd J.**	042	Cape Girardeau
Lund, Herluf G., Jr.	190	Chesterfield
Lund, Herluf G., Sr.	190	St. Louis
Lundman, Hugh	082	Springfield
Lurie, H. H.	082	Springfield
***Lustig, Richard W.**	126	Olathe, KS
Luther, George A.	190	St. Louis
Luther, Priya O.	218	Columbia
Lutkewitte, Joseph F.	174	Ste. Genevieve
Lux, Gregory K.	082	Springfield
Luzania, Randy C.	125	Overland Park, KS
Luzecky, Michael H.	082	Springfield
Lyle, Robert R.	120	Versailles
Lyles, Rodney	125	Overland Park, KS

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*Doctor of Osteopathy

Lyman, Edward H.	190	St. Louis
Lyn-Kew, Kenneth E.	216	Hackensack, NJ
Lynch, Thomas W.	082	Springfield
Lynchard, G. Shawn	218	Columbia
Lyon, David B.	125	Prairie Village, KS
Lyons, Daniel F.	082	Springfield
Lyskowski, John C.	058	Jefferson City
Lyskowski, Maria M.	058	Jefferson City
Lyss, Carl A.	190	St. Louis
Lytle, Edwin L.	190	St. Louis
Lytle, Michael F.	125	Shawnee Mission, KS

M

Maas, James	222	St. Louis
Maben, Pamela S.	125	Independence
Maben, Sam E.	125	Kansas City
Maccotta, Luigi	222	St. Louis
Macdonnell, Thomas M.	210	Marshfield
Mack, Marvin L.	026	Columbia
Mackey, Kevin E.	216	Ballwin
Macleod, Angus	190	St. Louis
MacDonald, Robert R., III	195	St. Louis
MacDonald, Robert R., Jr.	190	St. Louis
MacGorman, Linda R.	082	Springfield
MacLaughlin, James C.	102	Hot Springs, AR
MacNaughton, Ralph E.	125	Shawnee Mission, KS
MacNaughton, Robert A.	125	Louisburg, KS
MacNaughton, Robert A., II	050	Liberty
Madden, Tessa	222	St. Louis
Maddipati, Sreedevi	190	St. Louis
Madduri, Aruna D.	034	Poplar Bluff
Madduri, Sivaprasad D.	034	Poplar Bluff
Madrid, Dominador O.	190	St. Louis
***Madsen, Dana M.**	058	Jefferson City
Madsen, Parley W.	190	St. Louis
Maender, Christopher W.	216	St. Louis
Maere, Janine M.	216	St. Louis
Magaletta, George E.	002	St. Louis
Magalski, Anthony	125	Kansas City
Magas, Louis	216	St. Louis
Magaw, David C.	066	Everton
Magee, Robert L.	214	Eldorado Springs
Magee, W. Edwin	190	Imperial
Magruder, Lyell M.	214	Nevada
Mahaffey, Brian L.	082	Springfield
Mahboubi, Aziz O.	202	Scottsdale, AZ
Mahmoud, Said F.	125	Kansas City
Mahoney, Heather	222	St. Louis
Mahoney, Kevin R.	082	Springfield
Main, Michael L.	125	Kansas City
Mais, Thomas E.	125	Shawnee Mission, KS
Maitz, Carlos A.	190	St. Ann
Major, Troy E.	082	Springfield
Majors, Patrick F.	190	St. Louis
Majzoub, Hish S.	102	Joplin
Makos, Mignon M.	030	St. Joseph
Maliszewski, James A.	125	Kansas City
Mallouk, Alexander G.	125	Kansas City
Malmberg, Virgil L.	190	Chesterfield
Mangum, William B.	125	Independence
Mani, Mary E.	190	St. Louis
Manire, John E.	102	Joplin
Mann, James K.	150	Hannibal
Mann, Margaret	222	St. Louis
Mannis, Charles I.	190	St. Louis
Manske, Paul R.	190	St. Louis
Mantell, Jack M.	082	Springfield
Maple, Francis M.	082	Springfield
Marbarger, John P., Jr.	190	St. Louis
Marchiando, Albert W.	207	Washington
Marchosky, J. Alex	190	Chesterfield
Marcus, Michael D.	190	St. Louis
Margenthaler, Julie	195	St. Louis
Margolis, David M.	190	St. Louis
Margolis, Robert P.	190	St. Louis
Mariano, Jennifer	218	Columbia
Marietta, William G.	042	Cape Girardeau
Marks, James	190	St. Louis
Markway, Gregory A.	125	Independence
Marrs, David B.	189	St. Charles
Marsh, Jeffrey L.	190	St. Louis
Marshall, Benjamin M.	218	Columbia
Marshall, Hal E.	125	Overland Park, KS
Marshall, Jay P., II	190	Chesterfield
Marshall, Michael P.	002	Kansas City
Marshall, Shirley A.	216	St. Louis
Marshall, William G.	026	Glasgow
Marshall, William H.	058	Jefferson City
Marti, Larry B.	135	Rolla
Martin, Andrea R.	218	Columbia
Martin, Chris J.	026	Columbia
Martin, Clarence A.	102	Joplin
Martin, Daniel J., Jr.	190	St. Louis
Martin, Daniel J., Sr.	190	St. Louis
Martin, David S.	190	Chesterfield
Martin, Jeffrey W.	190	St. Louis
***Martin, Kevin J.**	014	Vandalia
Martin, Mark W.	125	Lee's Summit
Martin, Richard A.	042	Cape Girardeau
Martin, Robert A.	206	West Plains
Martin, Sam	218	Columbia
Martin, Scott A.	190	St. Louis
Martin, Stanley B.	190	St. Charles
Martinez, Christopher	222	St. Louis
Martini, John A.	222	St. Louis
Marty, David R.	058	Jefferson City
Martz, John C.	190	St. Louis
Maska, Monte D.	082	Springfield
Maslan, Mark J.	125	Overland Park, KS
Mason, John E.	195	Clayton
Mason, Mary V.	195	Clayton
Mason, Mary Jane	135	Steelville
Mass, Joan H.	190	St. Louis
Massey, Vickie	125	Kansas City
Masters, Edwin J.	042	Cape Girardeau
Masters, William H.	190	Tucson, AZ
Mathews, Jeffrey E.	190	St. Louis
Matile, Gerald U.	125	Kansas City
Matlock, Eric V.	224	Kansas City
Matlock, Mark S.	102	Joplin
Matovich, Violet B.	125	Kansas City
Matson, Jeffrey A.	125	Kansas City
Matta, Camille S.	125	Kansas City
Mattax, James B., Jr.	082	Springfield
Matthews, J. Mark	125	Kansas City
Matthews, John G.	190	Shawnee Mission, KS
Matthews, John I.	058	Jefferson City
Matthews, Thomas D.	207	Washington
Maughs, Sydney B.	190	St. Louis

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Maupin, Kathy C.	190	Florissant
Maxson, Katherine A.	190	Chesterfield
Maxson, Theodore R.	110	Warrensburg
May, Kathryn E.	222	St. Louis
Mayer, Robert A.	190	Pocono Pines, PA
Mayes, Ben R.	190	St. Louis
Maylack, Fallon H.	190	Florissant
Maynard, Colleen M.	125	Kansas City
Mayuga, Edgardo G.	190	St. Louis
Mayus, Joseph L.	082	Springfield
Mazurek, Julie M.	125	N. Kansas City
McAfee, Gordon	082	Springfield
McBane, Amanda C.	218	Pacific
McBride, D. Scott, Jr.	218	Columbia
McBride, Marsha M.	195	St. Louis
McBridge, Megan C.	224	Kansas City
McCadden, Michael E.	190	St. Louis
McCalla, John P.	050	Kansas City
McCallister, Ben D.	125	Kansas City
McCanse, Andrew	125	Belton
McCanse, Lynn R.	050	N. Kansas City
McCarthy, Christopher E.	190	St. Louis
McClain, Thomas D.	082	Springfield
McClellan, James S.	222	St. Louis
McClune, Grant L.	042	Cape Girardeau
McConchie, James E.	125	Lee's Summit
McCorcle, Marcus D.	082	Springfield
McCord, E. Scott	026	Columbia
McCormack, Robert E.	125	Kansas City
McCormack, Thomas J.	125	Independence
McCormick, James E.	050	Kansas City
McCown, Allan H.	190	St. Louis
McCoy, Frederick J.	125	Shawnee Mission, KS
McCray, Glen M.	082	Springfield
McCray, Stephen A.	050	N. Kansas City
McCroskey, Brian L.	125	Kansas City
McCroskey, Lon C.	125	Kansas City
McCullough, Joseph E.	125	Kansas City
McDaid, Dawn M.	218	Columbia
McDavid, Robert E.	026	Columbia
McDonald, James H.	125	Kansas City
McDonald, Michael G.	102	Joplin
McDonald, Wallace	030	St. Joseph
McDonnell, John F.	125	Kansas City
McDonough, Michael	190	St. Louis
McDowell, James W.	046	Macon
McDowell, Juri O.	218	Columbia
McElroy, George L., III	058	Jefferson City
McElroy, Glenn L.	026	Columbia
McEwen, Gary W.	125	N. Kansas City
McFadden, Gene A.	118	Waverly
McFarland, Rodney J.	166	Neosho
McGahee, C. Leon	190	St. Louis
McGinnis, William F.	190	Chesterfield
McGinty, Charles P.	042	Cape Girardeau
McGinty, Frank H.	042	Cape Girardeau
McGonigle, James P.	102	Longboat Key, FL
McGonigle, Michael M.	102	Joplin
McGovney, Janice K.	050	Kansas City
McGranahan, Rita	216	St. Louis
McGregor, Patrick E.	050	N. Kansas City
McGuire, Patricia A.	190	St. Louis
McIlwaine, James W.	218	Columbia
McIntire, Timothy L.	058	Jefferson City
McIntosh, Donald E.	125	Lee's Summit
McIntosh, Douglas A.	042	Cape Girardeau
McIntosh, Michele C.	125	Independence
McKeel, Thomas B.	125	Kansas City
McKeown, Robert A.	206	Kansas City
McKinley, Lois J.	125	Kansas City
McKinney, John W.	190	St. Louis
McKinsey, David S.	125	Kansas City
McKnight, Scott J.	050	Liberty
McLaren, David L.	026	Columbia
McLaughlin, Richard D.	082	Springfield
McLemore, Willie O.	125	Kansas City
McMahon, Robert	190	St. Louis
McManus, Gerald	050	N. Kansas City
McMillan, David L.	166	Neosho
McMillen, James J.	030	St. Joseph
McMorrow, Nora K.	190	Crestwood
McMullin, Forbes A.	190	St. Louis
McMurray, Scott W.	082	Springfield
McMurry, Ted A.	082	Springfield
***McNabb, M. Jeffery**	042	Cape Girardeau
McNamara, Gerald R.	125	Kansas City
McNay, Jennifer A.	082	Springfield
McNeal, Douglas M.	082	Springfield
McPhee, Mark S.	125	Kansas City
McQueary, Frederick G.	082	Springfield
Meade, Tonya P.	226	Cape Girardeau
Meadows, C. Douglas	190	St. Louis
Meagher, Leah K.	216	St. Louis
Mecker, Robert	207	Washington
Medler, John F.	190	Chesterfield
Medler, P. Louis	190	St. Louis
Medler, Robert G.	190	St. Louis
Medlicott, William J.	125	Port Townsend, WA
Medling, Bradley D.	218	Columbia
Meece, David R.	042	Cape Girardeau
Mehaffy, Orville A.	102	Joplin
Mehlhorn, Gary L.	082	Springfield
Mehr, David R.	026	Columbia
Mehra, Ravi	190	St. Louis
Meidl, Erik J.	150	Hannibal
Meidl, Susan M.	150	Hannibal
Meier, Francis X.	058	Jefferson City
Meier, Mitchell S.	102	Joplin
***Melchior, David E.**	174	Perryville
Meldi, Dominic M.	082	Springfield
Melia, B.J., Jr.	125	Kansas City
Mell, Roger L.	190	Chesterfield
***Mellies, Steven D.**	042	Cape Girardeau
Meltz, Gary J.	189	St. Charles
Memken, John A.	150	Hannibal
Memmolo, Ciriaco A.	190	St. Louis
Mendelsohn, George E.	190	Chesterfield
Mendez-Castillo, Alejandr	027	Columbia
Mendonsa, Lawrence E.	190	Chesterfield
Menitove, Jay E.	125	Kansas City
Menne, Marvin C.	138	Ironton
Mentgen, Carl N.	082	Springfield
Merenda, Frank J.	190	St. Louis
Merenda, James T.	190	St. Louis
Merrill, Daniel K.	216	St. Louis
Merritt, Burch A.	190	St. Louis
Merritt, Gregory A.	125	Kansas City
Mesa, Luis J.	126	Kansas City

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Messmore-Arn, V. Paula	125	Kansas City
Mestad, Peter H.	125	Kansas City
Mestres, Hugh M.	190	Valley Park
Metzler, Michael H.	026	Columbia
Meurer, Michael F.	082	Springfield
Meyer, D. Joseph, Jr.	026	Columbia
Meyer, Jay L.	190	St. Louis
Meyer, Jerry L.	118	Concordia
Meyer, John S.	190	Chesterfield
Meyer, John W.	082	Springfield
Meyer, Paul W.	125	Shawnee Mission, KS
Meyer, Randall E.	058	Jefferson City
Meyer, Robert C.	190	St. Louis
Meyers, Elsie F.	190	St. Louis
Meyers, Jerry R.	189	St. Peters
Meyers, John B.	190	Clayton
Meyers, Robert W.	190	St. Louis
***Meyers, Sharon A.**	190	St. Louis
Meystrik, Rosellen S.	082	Springfield
***Michael, Roy A.**	058	Jefferson City
Michael, Vernon E.	190	St. Louis
Michaels, Robert H.	082	Springfield
Michelson, Richard B.	125	Kansas City
Middleton, Jerry N.	190	Chesterfield
Middleton, Mary Jo	030	St. Joseph
Miedema, Brent W.	026	Columbia
Mierisch, Raymond F.	218	Columbia
Mihalevich, John A., Jr.	082	Springfield
Miki, Roberto	222	St. Louis
Milburn, James M.	002	Chesterfield
Milder, Barry D.	190	St. Louis
Miles, George O.	125	Shawnee Mission, KS
Miles, Judith H.	026	Columbia
Miles, Wayne B.	082	Springfield
Milgram, Byron A.	125	Kansas City
Mill, William B., Jr.	190	St. Louis
Miller, Charles W.	190	St. Louis
Miller, Dace L.	082	Springfield
Miller, Denise M.	125	Leawood, KS
Miller, Donald	058	Jefferson City
Miller, Gerald L., Jr.	125	Kansas City
Miller, Harry G.	086	Clinton
Miller, Jessica	222	St. Louis
Miller, John T.	125	N. Kansas City
Miller, Joseph P.	042	Cape Girardeau
Miller, Jule P.	190	St. Louis
Miller, Michael V.	226	Cape Girardeau
Miller, Michelle M.	216	Webster Groves
Miller, Noelle E.	216	St. Louis
Miller, Robert N.	190	St. Louis
Miller, Thomas A.	002	St. Louis
Miller, William D.	030	St. Joseph
Miller, Wilson H.	125	Overland Park, KS
Millett, Ruth E.	125	Kansas City
Mills, Paul B.	218	Creve Coeur
Milne, Jay L.	082	Springfield
Minder, Angela R.	216	Romulus, MI
Miner, Edward	222	St. Louis
Minnigerode, Lana K.	125	Kansas City
Minnigerode, Turner L.	125	Kansas City
Mir, A. Rauf	125	Kansas City
Mirbaha, Mitchell M.	190	St. Louis
Mire, Louis E.	208	Branson
Mirkin, Rhoderic P.	002	St. Louis
Mischnick, Carol R.	190	Chesterfield
Miskovsky, Emil F.	190	St. Louis
Mistry, Tehmton S.	190	Columbia, IL
Mitchell, Andrew D.	125	Prairie Village, KS
Mitchell, Franklin L.	026	Columbia
Mitchell, Jason	027	St. Peters
Mitchell, John D.	125	Kansas City
Mitchell, Lynn D.	026	Columbia
Mitchell, Scott	222	St. Louis
Mitra, Nirmal K.	125	Kansas City
Mitri, Osama	126	Kansas City
Mittelstadt, Margaret	218	Columbia
Mizell, Myron W.	082	Springfield
Moats, Scott L.	126	Kansas City
Mobley, Gilbert L.	082	Springfield
Mockli, Gary C.	190	St. Louis
Moeller, F. Delbert	189	Lake St. Louis
Moffe, Thomas C.	082	Springfield
Mogensen, Monique	222	St. Louis
Mogilishetty, Gautham	126	Kansas City, KS
Mohs, Frank R.	190	St. Louis
Mohsen, Aly M.	082	Springfield
Molberg, Peter J.	082	Springfield
Molden, C. Scott	190	St. Louis
Molden, Charles A.	190	St. Louis
Molitor, Christopher E.	218	Ste. Genevieve
Mollman, H. Dennis	190	Chesterfield
Monaco, Michael	125	Harrisonville
Monaghan, Greg G.	026	Columbia
Montani, David M.	195	St. Louis
Monteleone, Patricia L.	190	St. Louis
Montello, Samuel A.	125	Shawnee Mission, KS
Monterubio, Fred R., Jr.	190	St. Louis
Montes, Arturo C.	190	Florissant
Montgomery, Austin F.	190	St. Louis
Montgomery, Michael A.	125	N. Kansas City
Montie, Joseph E.	026	Columbia
Moolsintong, Picha	218	Columbia
Moon, Charles M.	218	San Antonio, TX
Mooney-Smith, Patricia	125	Kansas City
Moore, Angela C.	226	Cape Girardeau
Moore, Brian D.	126	Kansas City
Moore, Candice A.	214	Nevada
Moore, Christine M.	126	Smithville
Moore, John D.	195	Ballwin
Moore, John M.	002	Kansas City
Moore, Matthew G.	222	Ann Arbor, MI
Moore, Michael R.	206	West Plains
Moore, Michael T.	214	Nevada
Moore, Richard E.	042	Cape Girardeau
Moore, Thomas B.	102	Joplin
Moran, Thomas M.	190	St. Louis
Morantz, Robert A.	125	Kansas City
Moranville, Benedict A., II	030	Shawnee, KS
Morehead, William E.	070	Malden
Morehouse, Paul D.	110	Warrensburg
Morello, Patrick J.	058	Jefferson City
Moretina, Jennifer L.	126	Lenexa, KS
Moreton, David W.	026	Columbia
Moretz, J. Alfred, III	042	Cape Girardeau
Morey, Kirk P.	190	St. Louis
Morgan, David B.	125	Kansas City
Morgan, Dix R.	042	Cape Girardeau
Morgan, Edward B.	190	St. Louis

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*Doctor of Osteopathy

Morgan, Harry C.	**190**	Waynesville
Morgan, Stephan S.	**190**	St. Louis
Morgan, Vincent I.	**026**	Columbia
Morgan, W. Tom, Jr.	**026**	Columbia
Morgan, Willy J.C.	**190**	E. St. Louis, IL
Moriconi, William J.	**190**	St. Louis
Moritz, Gerald	**190**	Bridgeton
Moritz, K. Lynne	**190**	St. Louis
Morley, Mary A.	**190**	Chesterfield
***Morley, Ronald F.**	**058**	Jefferson City
Morlin, Gregory L.	**218**	Columbia
Morris, Alan H.	**190**	St. Louis
Morris, Carolyn M.	**195**	St. Louis
Morris, John J.	**026**	Columbia
Morris, R. William	**190**	St. Louis
Morrison, R. Gideon	**206**	West Plains
Morrison, Richard A.	**125**	Independence
Morrison, Robert R.	**050**	Kansas City
Morrison, Tom V.	**208**	Branson
Morrow, N. Eugene	**082**	Springfield
Morton, Wayne L.	**214**	Osceola
Mosby, Larry D.	**026**	Columbia
Moseley, F. Thomas	**082**	Springfield
Mosher, Amy A.	**190**	St. Louis
Mosley, Julian C.	**190**	St. Louis
Moss, Debra L.	**190**	Chesterfield
Moss, Paul	**125**	Overland Park, KS
Mossie, Raymond D.	**002**	Kansas City
Mossinghoff, Deborah A.	**125**	Kansas City
Motchan, Dennis G.	**190**	Bridgeton
Motier, Thomas H.	**190**	St. Louis
Motoc, Vlad T.	**126**	Carroll, IA
Muchnick, Richard L.	**190**	St. Louis
Muckerman, Richard C., II	**190**	St. Louis
Muckerman, Richard I.C.	**190**	St. Louis
Muegge, F. David	**082**	Springfield
Muehlenbein, Joan	**216**	St. Louis
Mueller, Adolph R.	**102**	Joplin
Mueller, Clarence E.	**190**	O'Fallon
Mueller, Cynthia J.	**190**	St. Louis
Mueller, Janet G.	**190**	St. Louis
Mueller, Joseph A.	**190**	St. Louis
Mueller, Kristin	**216**	St. Louis
Mueller, Martin J.	**125**	Kansas City
Mueller, Randall E.	**026**	Columbia
Muhm, H. Yale	**189**	St. Charles
Mujica, Patricio H.	**030**	St. Joseph
Mullarky, Wilbur A.	**190**	Oviedo, FL
Mullen, Jack	**138**	Bonne Terre
Mullen, Mary E.	**014**	Mexico
Mullican, Charles N.	**030**	St. Joseph
Mullick, Monalisa	**126**	Lenexa, KS
Mullins, Bernard L.	**050**	Gladstone
Mullins, Eric S.	**218**	Columbia
Mullins, J. Randolph	**082**	Springfield
Mullins, John E.	**190**	St. Louis
Muncy, Gary A.	**190**	Chesterfield
Mundy, William L.	**125**	Merriam, KS
Munger, Michael L.	**125**	Kansas City
Munoz, Phillip A.	**125**	Kansas City
Munro, John S.	**125**	Kansas City
Muraywid, Ahmad H.	**014**	Mexico
Murdock, Nathaniel	**190**	St. Louis
Murphy, Brian A.	**222**	DeCatur, IL
Murphy, J. Peter, Jr.	**190**	St. Louis
Murphy, James A.	**030**	St. Joseph
Murphy, John P.	**125**	Overland Park, KS
Murphy, Timothy P.	**030**	St. Joseph
Murray, Timothy R.	**126**	Kansas City, KS
Murrell, H. Jerry	**026**	Columbia
Muscato, Joseph J.	**026**	Columbia
Muscato, Mary S.	**026**	Columbia
Musleh, Wael	**216**	Marina Del Rey, CA
Mutchnick, Norman	**125**	Kansas City
Muzaffar, Samar S.	**218**	Columbia
Myers, Carl M.	**125**	Platte City
Myers, Duane E.	**102**	Joplin
Myers, Gary H.	**190**	Chesterfield
Myers, George H.	**125**	Kansas City
Myers, John S.	**125**	Kansas City
Myers, Timothy P.	**218**	Columbia

N

Nachtigal, Michael P.	**082**	Springfield
Nadolski, Gary S.	**030**	St. Joseph
Nagle, Michael G.	**102**	Joplin
Nagy, Al L.	**034**	Doniphan
Nagy, Rickey E.	**125**	Kansas City
Nanson, Duane	**026**	Columbia
Narayan, Dilip L.	**190**	Chesterfield
Naseer, Saad A.	**220**	Kansas City
Nash, Helen E.	**190**	St. Louis
Nash, Homer E., Jr.	**190**	St. Louis
Nathan, Lester J.	**190**	Fenton
Naunheim, Keith S.	**190**	St. Louis
Nazareth, Norman M.	**126**	Kansas City
Ndum, Philip N.	**126**	Kansas City
Neal, Christopher J.	**218**	Columbia
Near, David M.	**190**	Florissant
Neblett, Lewis M.	**082**	Rogersville
Neely, J. Gail	**190**	St. Louis
Neighbor, Ernest H.	**125**	Kansas City
Neihart, Robert E.	**125**	Kansas City
Nelson, Bentley A.	**125**	Leawood, KS
Nelson, Donald C.	**082**	Springfield
Nelson, J. Roger	**190**	St. Louis
Nelson, Jeremiah	**220**	Kansas City
Nelson, Michael J.	**125**	Lee's Summit
Nelson, Richard E.	**125**	Kansas City
Nelson, Steven C.	**126**	Kansas City
Nepute, James A.	**190**	St. Louis
Nesselrode, John H.	**125**	Independence
Nestleroad, Christopher A.	**218**	Columbia
Nestor, Kimberly A.	**224**	Overland Park, KS
Neu, Kenneth W.	**082**	Springfield
Neu, Leo T., III	**082**	Springfield
***Neuenswander, Keith W.**	**050**	Independence
Neuman, Neal	**190**	St. Louis
Nevett, Robert E.	**207**	Washington
Newby, Crystal	**220**	Overland Park, KS
Newland, Craig C.	**050**	Liberty
Newman, Joseph A.	**102**	Joplin
Newman, Mary J.	**166**	Cassville
Newman, William R.	**102**	Joplin
Newman-Koehn, Mica K.	**198**	Marshall
Newmann, Tyson V.	**218**	Columbia
Newport, Gerald	**190**	Florissant
Ngo, Chan K.	**216**	St. Louis
Nguyen, Helen T.	**030**	St. Joseph

Nicholas, Stephen P. St. Louis	**190**
Nichols, Dave P. Columbia	**218**
Nichols, Margaret E. Joplin	**102**
Nichols, W. Kirt Columbia	**026**
Nickell, Margaret B. Kansas City	**125**
Nickell, Michael D. Joplin	**102**
Nicolai, Charles H. St. Louis	**190**
Nicolazzi, Anne-Marie M. St. Louis	**190**
Niedermeyer, George J. St. Louis	**190**
Nielsen, Carl H. St. Louis	**190**
Niemeyer, John H. St. Louis	**190**
Niesen, Anna R. St. Louis	**190**
Niesen, Frank J. St. Louis	**190**
Niesen, Thomas E. Chesterfield	**190**
Nigh, Stephen S. Kansas City	**125**
Nigro, Thomas L. Kansas City	**125**
Nile, David A. St. Louis	**190**
Nishi, Toshio St. Louis	**190**
Nissing, Matthew St. Louis	**222**
Nix, J. Gustavo Bolivar	**066**
Noback, Richardson K. Las Vegas, NV	**125**
Noe, Joshua D. St. Louis	**216**
Noel, Alan DeMesa Steelville	**135**
Nogalski, Michael P. St. Louis	**190**
Noltensmeyer, Milton H. Lenexa, KS	**125**
Nomura, Roy M. St. Louis	**190**
Nordhues, Craig A. Springfield	**082**
Norland, Charles C. St. Louis	**190**
Norman, Annika M. Jefferson City	**218**
North, Carol S. St. Louis	**190**
North, Michael S. Springfield	**082**
Nosovitch, Mace A. Columbia	**218**
Nottmeier, Eric W. Columbia	**027**
Nouri, Hassan St. Louis	**190**
Novack, Mark A. Chesterfield	**190**
Nowland, Matthew P. Ft. Collins, CO	**218**
Nowotny, Thomas J. St. Louis	**190**
Nuetzel, John A. St. Louis	**190**
Nwaobasi, Sam Florissant	**190**
Nye, Robert A. St. Louis	**190**
Nye, Terry R. Springfield	**082**

O

Oakley, Margaret M. St. Louis	**190**
Oberkrom, David W. Sedalia	**178**
Oberle, Paul A. Ballwin	**190**
O'Brien, Edward J., Jr. St. Louis	**190**
Occeno, Victor G. Cassville	**166**
Ochoa, Pedro Valmeyer, IL	**190**
Ockner, Samuel A. Chesterfield	**190**
O'Connell, Ellen S. Des Peres	**216**
O'Connell, Timothy St. Louis	**190**
O'Connor, Mary C. Kansas City	**125**
O'Connor, Robert J. Florissant	**190**
Oda, Joanna St. Louis	**222**
O'Donnell, Francis E. St. Louis	**190**
O'Donnell, Gregory P. Overland Park, KS	**125**
O'Donnell, Susan M. Ste. Genevieve	**174**
O'Dowd, Mary K. Chesterfield	**002**
Oertli, Robert St. Louis	**190**
Offner, Jennifer K. Palmyra	**150**
Ofori, Abena St. Louis	**222**
Ogden, A.M. Allison St. Louis	**222**
Ogden, Justin S. Columbia	**218**
Oge, Erica L. Kansas City	**220**
Ogle, William R.M. Cape Girardeau	**042**
Oh, Jung D. St. Louis	**222**
Oh, Sangjin St. Louis	**216**
O'Hara, Patrick W. Kansas City	**126**
O'Hearne, John J. Kansas City	**125**
Ohlhausen, Ward W. Liberty	**050**
Ohlms, David L. St. Louis	**190**
Ojascastro, Alejandro C. St. Louis	**190**
Ojascastro, Lou St. Louis	**190**
O'Keefe, James H., Jr. Kansas City	**125**
Oldeg, Paula F. St. Louis	**216**
Oleson, Gale B. Blue Springs	**125**
Olive, George C. Neosho	**166**
Olive, Paul M. Springfield	**082**
Oliver, G. Charles St. Louis	**002**
Oliver, George A. Farmington	**138**
Oliver, Malcom B. Republic	**002**
***Olomon, Angela S.** Gladstone	**050**
Olsen, Teresa A. Springfield	**082**
Olson, E. Rule Rogersville	**082**
Olson, Gary S. Cape Girardeau	**042**
Olson, James H. Liberty	**050**
Olson, Lloyd C. Kansas City	**125**
Olson, Richard O. St. Charles	**189**
O'Malley, James F. Leawood, KS	**125**
Omell, Gary H. St. Louis	**190**
Onder, Robert F. St. Louis	**190**
O'Neal, Lawrence W. St. Louis	**190**
O'Neil, Jerome H., Jr. St. Louis	**190**
O'Neill, Hugh B. Abingdon, MD	**216**
Ong, Ofelia S. St. Louis	**190**
Onken, Henry D. St. Louis	**190**
Oppenheimer, Henry E. St. Louis	**190**
Opper, Susan E. Kansas City	**125**
Oppermann, Karen J. Independence	**125**
Orgel, S. Michael St. Louis	**190**
Orlando, Louis A. Lee's Summit	**125**
Oro, John J. Columbia	**026**
Orr, Robert M. N. Kansas City	**050**
Orr, Steven M. Parkville	**125**
Orscheln, Karl J. Columbia	**218**
Ortbals, David W. Chesterfield	**190**
Ortmeyer, Leroy F. St. Louis	**190**
Osbourn, Richard A. Fulton	**038**
Ost, Mark D. Kansas City	**125**
Ostapowicz, Tamara L. St. Louis	**190**
Ostergaard, Daniel J. Kansas City	**125**
O'Sullivan, Daniel F. St. Louis	**190**
Ota, David M. Columbia	**026**
Otis, Stephanie A. Town & Country	**190**
O'Toole, Patrick M. Kansas City	**125**
Ott, F. Thomas St. Louis	**190**
Ott, Harold J., II St. Louis	**190**
Ott, William J. St. Louis	**190**
Otto, Steven M. Springfield	**082**
Otto, William J. Springfield	**082**
Ouellette, David F. Hannibal	**150**
Overend, Don S. Springfield	**082**
Overesch, Harry B. Kansas City	**125**
Owen, Robert F. St. Louis	**190**
Owens, Robert H. Shawnee Mission, KS	**125**
Owens, William D. St. Louis	**190**
Ozar, Milton B. Miami, FL	**125**
Ozenberger, Larry Plattsburg	**054**

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P

Pacheco, Jose M.	082	Springfield
Packman, Paul	190	St. Louis
Packman, Robert C.	190	St. Louis
Padilla, Teresita C.	190	Chesterfield
Padula, Richard T.	125	Shawnee Mission, KS
Paek, Sandra	222	St. Louis
Paez, Mauro A.	190	St. Louis
Page, Jennifer L.	190	St. Louis
***Page, Jordan C.**	126	Kansas City
***Page, Lawrence V.**	102	Joplin
Page, Sam L., Jr.	190	St. Louis
Painter, Andrew E.	202	Portageville
Painter, Lattie B.	170	Portageville
Palagiri, Ashok V.	216	St. Louis
Palaniappan, Meyyappan	034	Doniphan
Palazola, Joseph M.	125	Kansas City
Palcheff, Chris L.	082	Springfield
Palen, James E.	042	Cape Girardeau
Palenske, Robert L.	070	Hornersville
Paletta, Francis X., Sr.	190	St. Louis
Paletta, Frank	190	St. Louis
Palmer, Stephen M.	190	St. Louis
Pancoast, Charles H.	042	Cape Girardeau
Pankau, Billi Sue	220	Kansas City
Pao, Vivian	222	St. Louis
Paone, Douglas B.	125	Kansas City
Papreck, K. T.	198	Marshall
Paradelo, Jorge C.	125	Kansas City
Parghi, Sharvari R.	218	San Antonio, TX
Parikh, Parag	222	Northville, MI
Parikh, Sharad P.	190	Florissant
Paris, William H.	190	Bridgeton
Park, Duk J.	106	Festus
Park, Kee B.	042	Cape Girardeau
Park, William I., Jr.	082	Springfield
Parker, Arthur C.	034	Tulsa, OK
Parker, Brent M.	026	Colorado Springs, CO
Parker, Craig A.	125	Kansas City
Parker, Derrall A.	042	Cape Girardeau
Parker, Kim E.	125	Kansas City
Parkins, George K.	125	Kansas City
Parks, Charles	190	St. Louis
Parks, David A.	190	St. Louis
Parks, Deborah L.	190	St. Louis
Parks, Joseph J.	026	Jefferson City
Parks, William C.	026	Columbia
Parra, Dana L.	126	Prairie Village, KS
Parres, Jeffrey A.	190	Chesterfield
Parrott, Heather N.	218	Columbia
Parsons, Clyde W., III	082	Springfield
***Parsonson, Robert**	148	Brookfield
Partamian, Krikor O.	030	St. Joseph
Partap, Sonia	220	Mission, KS
Partikian, Arthur	222	St. Louis
Partin, Mary Beth	218	Columbia
Parulekar, Dilip G.	038	Fulton
Parwatikar, Sadashiv D.	190	St. Louis
Paskar, Larry D.	190	Chesterfield
***Pasowicz, Timothy C.**	125	Shawnee Mission, KS
Passanante, Bartholomew	190	St. Louis
Patel, Ashokkumar B.	190	St. Louis
Patel, Dilip H.	190	St. Louis
Patel, Hitendra	126	Kansas City
Patel, Indu B.	106	Barnhart
Patel, Maitraya	222	St. Louis
Paterson, Jennifer L.	002	Washington
Patrick, Roman L.	190	St. Louis
Patterson, Donald C.	026	Columbia
Patterson, Donald R.	102	Joplin
Patterson, J. Megan	222	St. Louis
Patton, Theresa M.	220	Weatherford, TX
Patty, Carl F.	034	Poplar Bluff
***Patty, John R.**	034	Poplar Bluff
Paul, Michael J.	190	St. Louis
Paulson, Gordon S.	030	St. Joseph
Pavelonis, Joel D.	002	Kansas City
Pavlovich, Andrew S.	125	Independence
Pavlu, Robert R.	118	Waverly
Pawsat, John E.	125	Kansas City
Payne, David E.	026	Columbia
Payne, Meredith J.	190	St. Louis
Pearce, Eugene W. J.	125	Kansas City
Pearman, Carl C.	002	Kansas City
Pearse, Carlton S.	190	Chesterfield
Pearson, Richard L.	174	Ste. Genevieve
Pearson, William E.	190	St. Louis
Peck, William A.	190	St. Louis
Peden, Virginia H.	190	Maryland Heights
Peelle, Michael	222	St. Louis
Peeples, David M.	190	St. Louis
***Peer, Peter M.**	126	Kansas City
Pegis, Bernard T.	216	St. Louis
Pehlman, Joseph E.	070	Malden
Peick, Ann L.	190	St. Louis
Pelican, George	190	St. Louis
Penilla, Antonio R.	190	St. Louis
Penn, Patrick L.	125	Kansas City
Pennell, Richard C.	190	St. Louis
Pentella, Karen J.	190	St. Louis
Pepper, Edward G.	190	St. Louis
Pereira, MaryBeth	190	St. Louis
Perez, Carlos A.	190	St. Louis
Perez, Robert J.	190	St. Louis
Perinetti, Enrique P.	190	St. Louis
Perkins, David E.	190	Chesterfield
Perll, Maurice F., Jr.	125	Kansas City
Perll, Michael F.	125	Kansas City
Perll, Peter D.	014	Mexico
Perlmutter, John C.	189	St. Charles
Perna, Vincent P.	189	St. Louis
Pernoud, Flavius G., III	190	St. Louis
Pernoud, Flavius G., Jr.	190	St. Louis
Pernoud, Joan M.	190	St. Louis
Perry, Lindell A.	014	Mexico
Perry, Michael C.	026	Columbia
Perryman, Douglas R.	125	Kansas City
Perryman, J. Chris	125	Kansas City
Perryman, Kathy M.	125	Kansas City
Perschbacher, Jim M.	216	Chesterfield
Petelin, Joseph B.	125	Shawnee Mission, KS
Peters, David W.	126	Kansas City
Peters, Walter R.	026	Columbia
Petersen, James H.	002	Chesterfield
Petersen, Larry D.	082	Springfield
Peterson, Carl M.	125	Kansas City
Peterson, Craig A.	082	Springfield
Peterson, Frederick D.	190	St. Louis

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Peterson, Ila M. Leawood, KS	**125**
Peterson, Jay T. Kansas City	**125**
Peterson, Stephen E. Kansas City	**125**
Peterson, Walter R. Kansas City	**125**
Peterson, Wylan C. O'Fallon, IL	**220**
Petit, Carl A. Osage Beach	**120**
Petka, Tanya M. St. Louis	**222**
Petkovich, Frank O. St. Louis	**190**
Pettett, Gary Kansas City	**125**
Petty, Norman C. Columbia	**218**
Pew, Becky A. St. Louis	**190**
***Pewitt, Charles S.** Jackson	**042**
***Pfautsch, Mark L.** Cape Girardeau	**042**
Pfefferkorn, David A. Sikeston	**202**
Phelan, David Overland Park, KS	**125**
Philgreen, Donald E. Kansas City	**125**
Phillips, Abraham M. St. Louis	**190**
Phillips, Daniel St. Louis	**190**
Phillips, Grace St. Louis	**195**
Phillips, Granville J. Warrensburg	**110**
Phillips, John J. Florissant	**190**
Phillips, Kenneth D. Cape Girardeau	**042**
Phillips, Robert L. Columbia	**027**
Phillips, Ronald L. Kirksville	**148**
Phillips, Thomas P. Kansas City	**125**
Phillips, William J. Chesterfield	**190**
Philpott, Gordon W. St. Louis	**190**
Philpott, Timothy C. St. Louis	**190**
Piccirillo, Jay F. St. Louis	**190**
Pickard, Clarence M. Columbia	**026**
Picker, Selwyn St. Louis	**190**
Pickering, Lee I. Independence	**125**
Picus, Joel St. Louis	**002**
Piebenga, Larry W. Kansas City	**125**
Piening, Kurt A. St. Charles	**189**
Piephoff, James V. St. Louis	**190**
Pierce, Dan L. Columbia	**026**
Pineda, Hector O. St. Louis	**190**
Pineda, Juan J. Columbia	**026**
Pingelton, William B. Columbia	**026**
Pingleton, William W. Shawnee Mission, KS	**050**
Pinkham, Chris M. Kansas City	**050**
***Pioli, Lisa L.** Overland Park, KS	**125**
Piontek, James F. Liberty	**050**
Piontek, Jerome G. Chesterfield	**190**
Pitiyanuvath, Tasanaporn Kansas City	**125**
Pitney, Phillip W. Louisiana	**150**
Pitsinger, N. Bruce Chesterfield	**190**
Pittman, Gerald R. St. Louis	**190**
Pittman, Susan St. Louis	**190**
Pittmann, Thomas St. Louis	**190**
Pjura, George A. Cape Girardeau	**042**
Plax, Steven I. St. Louis	**190**
Podolsky, Howard S. St. Louis	**002**
Podrecca, Guido I. Key Largo, FL	**082**
Poe, Megan C. Columbia	**218**
Poger, Marshall E. St. Louis	**190**
Poggemeier, David A. St. Charles	**189**
Poggemeier, William H. St. Charles	**189**
Pogson, George W., III Independence	**125**
Pohl, David L. St. Louis	**190**
Pojanasomboon, Pichat Rolla	**135**
Politi, Gregory B. Kansas City	**125**
Politte, Lenard L. Columbia	**026**
Pon, Marcelino St. Louis	**190**
Ponstingl, Raana J. St. Louis	**190**
Poole, Anthony G. Sikeston	**202**
Poonawala, Huseni E. Kansas City	**125**
Popp, Dennis A. St. Louis	**190**
Porte, Karen L. Joplin	**102**
Porter, Charles B. Kansas City	**125**
Porter, Michael J. Kansas City	**125**
Porter, Susan S. Kansas City	**125**
Portnoff, Lee S. St. Louis	**190**
Portwood, Glen L. Kansas City	**125**
Porvaznik, John T. Chesterfield	**190**
Porvaznik, Michael E. St. Louis	**190**
Post, Stephen L. St. Louis	**190**
Postma, George S., Jr. Mission, KS	**125**
Pottenger, L. Kenneth Joplin	**102**
Potter, Caryl A., Jr. St. Joseph	**030**
Potts, Dan E. Chesterfield	**190**
Potts, Donald A. Kansas City	**125**
Potts, Gregory A. Washington	**207**
Potts, Matt Redlands, CA	**222**
Potts, Michael E. Columbia	**218**
Poulose, Abraham K. Prairie Village, KS	**125**
***Pourakbar, Mohammad** Olathe, KS	**126**
Powell, Alan E. Independence	**125**
Powell, Edwin M. Springfield	**082**
Powell, John A. St. Louis	**190**
Powell, Kenneth R. Springfield	**082**
Powers, Janette St. Louis	**216**
Prakash, Siddharth Columbia	**218**
Prasad, Chandra N. Jefferson City	**058**
Prater, Bill G. Springfield	**082**
Prater, Kimberly A. Springfield	**082**
Prater, Thomas G. Springfield	**082**
Pratt, Terrence Kansas City	**125**
Prelutsky, David J. St. Louis	**190**
Prensky, Arthur L. St. Louis	**190**
Presley, Jimmy C. Springfield	**082**
Prevallet, Kim E. Perryville	**218**
Previti, Vincent Springfield	**082**
Prey, Marianne U. St. Louis	**190**
Pribor, Elizabeth F. St. Louis	**190**
Price, Carl I. Springfield	**082**
Price, Hilton I. St. Louis	**190**
Price, Leigh A. Salem	**218**
Price, Patrick K. Shawnee Mission, KS	**125**
Price, Richard B. Overland Park, KS	**125**
Price, Richard C. Harrisonville	**214**
Price, Virginia St. Louis	**222**
Prickett, David C., Jr. Kearney	**050**
Prince, Yvonne M. Salem	**135**
Pringle, Scot G. Cape Girardeau	**042**
Pro, John D. Kansas City	**125**
***Probst, James E., Jr.** Jefferson City	**058**
Proctor, Donald C. Sedalia	**178**
Proskey, Vincent J. Chesterfield	**190**
Prough, Casey Kansas City	**220**
Prstojevich, Steven J. Kansas City	**125**
Pruett, Burchard S. Prescott, AZ	**190**
Pruett, Don S. St. Louis	**190**
Pruett, Paul L. Springfield	**082**
Pryor, Ira Joe Joplin	**102**
Puckett, Charles L. Columbia	**026**
Puckett, Lynn M. Columbia	**026**

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Pugh, Richard G. Blue Springs	125
Puglisi, Mark F. Kansas City	220
Purcell, Henry E. St. Louis	190
Purcell, John J., Jr. St. Louis	190
Purcell, Richard D. Springfield	082
Puro, Edward A. Florissant	190
Putnam, John L. Springfield	082
Pyeatte, Jacob P., Jr. Cape Girardeau	042

Q

Quiason, Arturo G. Independence	125
Quiason, Emmeline P. Independence	125
Quinn, Paul S. Springfield	082
Quinn, Rodney D. Springfield	082
Qureshi, Abdul R. St. Louis	190

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Raborar, Arteso C. Springfield	082
Racela, Luz S. Kansas City	125
Radakovich, Rick R. Kansas City	050
Rader, Edward S. St. Louis	190
Radford, Diane M. St. Louis	190
Radke, H. Karl Mission, KS	126
Radley, Anne M. Florissant	190
Ragan, Erin M. Columbia	218
Ragland, John E. Bonnots Mill	058
Rahman, Moudur Chesterfield	190
Rainey, Gordon Parms	220
Raju, Niranjana Ste. Genevieve	174
Rall, Kenneth L. Columbia	026
Rallo, Marcus C. St. Louis	216
Ramey, Ehret O. Kansas City	125
Ramirez, Ricardo M. Kansas City	034
Ramos, Americo G. Shawnee Mission, KS	125
Ramos, Ricardo R. Jacksonville, FL	190
Ramsey, J. Darryl Cape Girardeau	042
***Ramsey, Jesse R.** Cape Girardeau	042
Ramsey, Peter J. Columbia	218
Ramsey, Robert H. Bridgeton	190
Randolph, Bernard C. St. Louis	190
Randolph, Bernard C., Jr. Bridgeton	002
Randolph, Gary Joplin	102
Randolph, Kerry A. Springfield	002
Rangineni, Rajagopal St. Joseph	030
Rankin, Diane St. Louis	190
Rao, Ricardo Chesterfield	190
Rao, Sumati St. Louis	190
Rao, Vijaya Kumar P. Joplin	102
Rapp, Earl L. Hannibal	150
Rappold, Henry O. Chesterfield	002
Ratcliff, Keith M. Washington	207
Ratkin, Gary A. St. Louis	190
Ratliff, Kristin Cincinnati, OH	222
Ratts, Valerie S. St. Louis	002
Rau, Michael E. Washington	207
Ravindran, Priya D. Columbia	218
Rawlins, Fred E. Cape Girardeau	042
Rawson, Perry G. Washington	207
Ray, Adrian K. Columbia	218
Ray, Joel W. Cape Girardeau	042
***Ray, Terry L.** Columbia	026
Raybould, Michael W. Kansas City	125
Raybuck, Paula St. Louis	222
Raynor, Richard C. Marshall	198
Reaney, John A. Kansas City	002
Rearden, Timothy P. St. Louis	190
Reardon, James P. N. Kansas City	050
Reardon, Thomas F. St. Louis	190
Reardon, Thomas M. Liberty	050
Reddy, Abbiah N. Poplar Bluff	034
Reddy, Anchala N. West Plains	206
Reddy, Nalini A. West Plains	206
Reddy, Ramachandra Cape Girardeau	042
Reddy, Satish K. St. Louis	216
Reddy, Vinaya K. Columbia	218
Redington, James C. N. Kansas City	050
Redington, James C., Jr. St. Louis	190
Redmon, Conchita M. Springfield	082
Rednam, Krishnarao V. St. Louis	190
Reed, Glen H. Appleton City	214
Reed, Jeffrey T. St. Louis	190
Reed, Leea Springfield	082
Reeder, Charles C. Smithville	050
Reese, Adam Kansas City	220
Reese, Jon A. Springfield	082
Reese, Lester T. St. Louis	190
Reeves, Col., Glen I. Modesto, CA	190
Regas, Stephen L. Kansas City	125
Reh, Edward P., Jr. St. Louis	190
Reh, Thomas E. St. Louis	190
Reichert, Timothy J. St. Louis	190
Reinhardt, J. Robert R. Kansas City	125
Reintjes, Stephen L. N. Kansas City	125
Reisler, David M. Chesterfield	190
Reiss, Jacqueline L. Chesterfield	190
Reiss, Jeanne E. Kansas City	125
Reister, Philip D. Kansas City	125
Rejent, Anthony J. St. Louis	190
Remillong, Elizabeth L. Columbia	218
Rendleman, George F., Jr. St. Louis	190
Renner, Gregory J. Columbia	026
Retherford, Marta L. Columbia	218
Retter, Kenneth W. Cape Girardeau	042
Reuter, Gregory C. Mission, KS	125
Revels, Harry R., III Leawood, KS	125
Revels, Stephanie M. Fairway, KS	125
Reyes, Jose T. St. Louis	190
Reyes, Luis A. St. Louis	190
Reynolds, Richard R. Kansas City	125
Reynolds, Robert B., Sr. Carbondale, CO	190
Reynolds, Susan K. St. Louis	190
Reynolds, William R. Springfield	082
Rezvani, Laghaieh Sikeston	202
Rhoades, Charles E. Kansas City	125
Rhoads, Nicolle Kansas City	218
Rhodes-Stark, Kelly L. Kansas City	125
Riaz, Kamran Lenexa, KS	126
Riaz, M. Afzal Ste. Genevieve	174
***Ricci, Robert G.** Leawood, KS	125
Ricci, Walter J. Overland Park, KS	125
Rice, Karen H. Jefferson City	058
Rice, Kathleen G. Springfield	082
Rice, Lee Roy Joplin	102
Rich, Keith M. St. Louis	190
Rich, Margaret M. St. Louis	190
Richards, Dean D., III Overland Park, KS	125
Richardson, Brent A. Kansas City, KS	220
Richardson, Christy L. N. Kansas City	125
Richardson, Curtis J. St. Joseph	030

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Richardson, Donna T.	207	Union
Richardson, George A.	207	Union
Richardson, Norbert L.	207	Union
Richardson, Thomas F.	190	St. Louis
Richmond, Angela R.	082	Springfield
Richmond, Ron	042	Cape Girardeau
Ridenhour, C. E. Gene	026	Columbia
Ridgeway, William G.	190	St. Louis
Ridings, Harold D.	042	Cape Girardeau
Ridley, Thomas R.	216	St. Louis
Riechers, Thomas B.	207	Washington
Rieger, Frank G.	026	Columbia
Rigden, L. Brick	125	N. Kansas City
Rikli, Arthur E.	026	Columbia
Riley, Charles T.	118	Richmond
Riley, Joel Y.	002	St. Louis
Rinehart, Gregory C.	190	St. Louis
Riner, Ronald N.	190	St. Louis
Ring, Daniel S.	190	St. Louis
Ringer, C. Nelson	042	Cape Girardeau
Ringhofer, Brian R.	218	Columbia
Riojas, Lisa A.	135	Rolla
Riscoe, James M.	102	Joplin
Rising, Dean R.	082	Springfield
Rispler, David T.	058	Jefferson City
Ritter, C.J.	042	Cape Girardeau
Ritter, Carl F.	042	Sedona, AZ
Ritter, Hubert A.	190	Chesterfield
Ritter, Matthew J.	216	Florissant
Ritter, Ray A., Jr.	042	Cape Girardeau
***Rittman, Christopher J.**	208	Branson
Rivard, Robert	218	Columbia
River, George L.	102	Joplin
Rizzo, Adolfo E.	190	Palm Beach, FL
Roa, Necita L.	002	St. Louis
Robbins, Michael D.	218	Quincy, IL
Robbins, Philip L.	190	St. Louis
Robbins, Thomas D.	058	Jefferson City
Roberts, Charles C.	125	Kansas City
Roberts, Christopher H.	102	Joplin
Roberts, Grosvenor G.	125	Kansas City
Roberts, Harold K.	190	Clayton
Roberts, Howard H.	102	Joplin
Roberts, Jonathan M.	058	Jefferson City
Roberts, Perry T.	042	Oxford, MS
Roberts, Phyllis G.	030	St. Joseph
Robertson, Frank G.	190	Searcy, AR
Robertson, Terence A.	125	Leawood, KS
Robertson, William D.	034	Poplar Bluff
Robinett, Dawn	218	Columbia
Robinett, Wade V.	125	Kansas City
Robinow, Jay S.	125	Kansas City
Robinson, Arthur W.	125	Shawnee Mission, KS
Robinson, Darby	222	St. Louis
Robinson, Gary L.	082	Springfield
Robinson, Gordon H.	190	St. Louis
Robinson, Jay G.	125	Independence
Robinson, Melissa R.	226	Cape Girardeau
Robinson, Nicholas F.	070	Kennett
Robinson, Ronald L.	042	Cape Girardeau
Robinson, William J.	125	Overland Park, KS
Robison, Leon R.	190	Chesterfield
Robison, Paul D.	102	Joplin
Rodgers, George H.	125	Leawood, KS
Rodgers, Jody A.	058	Jefferson City
Rodgers, Saml U.	125	Kansas City
Rodgers, W. Blake	058	Jefferson City
Rodriguez, Fausto J.	218	Columbia
Rodriguez, Luis C.	195	Richmond Heights
Roe, Taiyun	222	St. Louis
Rogers, Casey	014	Mexico
Rogers, Cindy J.	216	St. Louis
Rogers, H. Bryan	190	St. Louis
Rogers, J. Drew	082	Springfield
Rogers, James D.	082	Springfield
Rogers, James T.	082	Springfield
Rogers, John T.	030	Osage Beach
Rogers, Robert L.	125	Shawnee Mission, KS
Roh, Joseph J.	125	Kansas City
Rohrback, Janelle M.	216	St. Louis
Rohrback, Scott M.	216	St. Louis
Roller, James A.	026	Columbia
Rollo, John L.	190	St. Louis
Romkema, George E.	190	St. Louis
Roper, Charles L.	190	St. Louis
***Rosales, Mark A.**	058	Linn
Rosecan, Marvin	190	Belleville, IL
Roselman, Michael J.	082	Springfield
Rosen, Howard M.	125	N. Kansas City
Rosen, Larry A.	125	Independence
Rosenbaum, Herbert E.	190	St. Louis
Rosenberg, David S.	190	Florissant
Rosenquist, Chris R.	042	Cape Girardeau
Rosenthal, Debra D.	190	St. Louis
Rosenthal, Howard G.	125	Kansas City
Rosenthal, William N.	125	Kansas City
Ross, Gilbert, Jr.	026	Columbia
Ross, Robert M.	125	Kansas City
Ross, William J.	190	Bridgeton
Roter, Alexander M.	189	St. Charles
Rotert, Eric M.	002	Winston-Salem, NC
Roth, Alfred D.	125	Mission, KS
Roth, John J.	190	St. Louis
Rother, Paul H.	189	St. Charles
Rothley, Lisa R.	218	Columbia
Rottler, Paul D.	190	St. Louis
Rouse, David T., Jr.	218	Columbia
Rouse, Ernest T., III	190	St. Louis
Roush, Randall D.	190	Florissant
***Routsong, Rodney T.**	190	St. Louis
Rowe, Vernon D., III	125	Kansas City
Rower, Jeremy A.	195	St. Louis
Roxas, Generoso P.	189	St. Charles
Roy, Tapankumar S.	190	St. Louis
Royce, Debra L.	102	Sarcoxie
Rozen, Jay I.	125	Kansas City
Ruble, Chad M.	220	Kansas City, KS
Rudloff, Mary A.	002	St. Louis
Rues, Lawrence A.	125	Kansas City
Ruess, Robert W.	042	Cape Girardeau
Ruff, Paul G.	082	Springfield
Rul-Lan, Carlos D.	002	Overland Park, KS
***Rummel, Theodore S.**	002	Wentzville
Rumpf, Ronald P.	026	Columbia
***Rupright, S. Jon**	026	Columbia
Russell, Garth S.	026	Palm Beach, FL
Russell, Herman E., Jr.	190	St. Louis
Russell, James L.	125	Leawood, KS

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Russell, John J.	**042**	Cape Girardeau
Russell, Kimberly A.	**126**	Kansas City
Russell, Mai T.	**216**	Clayton
***Russell, Robert B.**	**042**	Cape Girardeau
Russell, Robert K.	**125**	Kansas City
Russell, Scott S.	**126**	Kansas City, KS
Russell, Steven L.	**050**	Kansas City
Russell, Trent	**120**	Osage Beach
Rutherford, Barry D.	**002**	Kansas City
Rutledge, Paul G.	**216**	St. Louis
Ruwitch, Joseph F., Jr.	**190**	St. Louis
Ryall, Jo-Ellyn M.	**190**	St. Louis
Ryan, David	**078**	Trenton
Ryan, Michael H.	**195**	St. Louis
Ryan, Robert A.	**082**	Mission, TX
Ryan, Thomas J.	**058**	Jefferson City
Rymarquis, Lara A.	**222**	St. Louis
Rymer, Marilyn M.	**125**	Kansas City
Ryser, Carol A.	**125**	Kansas City

S

Saak, Thomas E.	**002**	St. Louis
Sabates, Felix N., Sr.	**125**	Prairie Village, KS
Sabates, Nelson R.	**125**	Prairie Village, KS
Sabates, Roland	**125**	Kansas City
Saboeiro, Gregory R.	**002**	St. Louis
***Sacha, Robert F.**	**042**	Cape Girardeau
Sachar, Jerome D.	**190**	St. Louis
Sadhu, Vijay K.	**026**	Columbia
Safley, Thomas J.	**125**	Independence
Sagar, Satya J.	**190**	St. Louis
Saghir, Marcel T.	**190**	St. Louis
Saha, Nitai C.	**190**	St. Louis
Saha, Sudha R.	**190**	St. Louis
Sahota, Pradeep K.	**026**	Columbia
Sakmar, Douglas A.	**190**	St. Louis
Sakurai, Mardmi	**222**	St. Louis
Salathe, Gregg J.	**082**	Springfield
***Saleh, George A.**	**050**	Kansas City
Salibi, Habbouba	**190**	Chesterfield
Sallee, David C.	**216**	St. Louis
Sallee, Skip	**190**	Ladue
Salmon, M. L.	**190**	Palm Harbor, FL
Salvador, Antonio	**190**	St. Louis
Samet, John M.	**190**	St. Louis
Sammon, T. James	**082**	Springfield
Sammons, Harry C.	**190**	Hermann
Samorodin, Janet E.	**224**	Kansas City
Samson, Barry L.	**190**	St. Louis
Samudrala, Ramulu	**190**	St. Louis
Samudrala, Suseela	**190**	St. Louis
Samuel, George P.	**034**	Doniphan
Samuelson, Thomas S.	**125**	Kansas City
Sanchez, Archie J.	**002**	Overland Park, KS
Sander, Jennifer S.	**218**	Columbia
Sanders, Jack S.	**058**	Jefferson City
Sanders, William F.	**125**	Kansas City
Sandiford, Patrick	**189**	St. Charles
Sandow, Theodore	**125**	Kansas City
***Sands, Michael E.**	**058**	Jefferson City
Sandza, Joseph G., Jr.	**190**	St. Louis
Sanfelippo, John F.	**058**	Jefferson City
Santanello, William M.	**190**	Belleville, IL
Saradih, Hassan M.	**126**	Prairie Village, KS
Sargent, Alden P.	**202**	Sikeston
Sargent, Eric W.	**002**	St. Louis
Sargent, Jennifer E.	**135**	Rolla
Sasser, William F.	**190**	St. Louis
Sato, George	**190**	Chesterfield
Sato, Richard W.	**190**	Chesterfield
Satterlee, C. Craig	**125**	Kansas City
Sauer, Gordon C.	**125**	Kansas City
Sawani, Arej M.	**218**	Columbia
Sawyer, Floyd E.	**050**	Ft. Lauderdale, FL
Sawyer, James	**190**	St. Louis
Saxe, Stephen J.	**042**	Cape Girardeau
Scacewater, Rick	**102**	Joplin
Scalzo, Anthony J.	**190**	St. Louis
***Scanlon, Robert C., II**	**082**	Springfield
Scearce, Robert L.	**058**	Jefferson City
Schaaf, Robert O.	**030**	St. Joseph
Schaberg, James E.	**189**	St. Charles
Schaberg, Kevin B.	**190**	Chesterfield
Schaefer, Glennon S.	**190**	St. Louis
Schane, Catherine L.	**082**	Springfield
Schaper, Ernest H.	**190**	St. Louis
Scharf, Daniel	**125**	Overland Park, KS
Scharrer, Alan J.	**110**	Holden
Scheibe, Robert G.	**190**	St. Louis
Scheible, Robert F.	**190**	St. Louis
Scheidt, Troy D.	**218**	Columbia
***Schekorra, Fred W.**	**058**	Camdenton
Schell, James A.	**026**	Columbia
Scheperle, Mark A.	**190**	St. Louis
Schermer, Jerrold A.	**026**	Columbia
Scherr, David D.	**058**	Jefferson City
Scheu, James H.	**190**	St. Peters
Schierman, William D.	**190**	St. Louis
Schiffmacher, Jack E.	**125**	Prairie Village, KS
Schillie, Gene A.	**125**	Kansas City
Schillie, Sarah F.	**218**	Columbia
Schiro, John E.	**054**	Cameron
Schlafly, Bruce S.	**190**	St. Louis
Schlafly, Edward F., Jr.	**190**	Chesterfield
Schlanger, Christopher M.	**218**	Columbia
Schlarman, David E.	**190**	St. Louis
Schlossman, David M.	**026**	Columbia
Schlozman, Daniel L.	**125**	Kansas City
Schmaltz, Richard A.	**026**	Columbia
Schmid, Tania L.	**190**	St. Louis
Schmidt, Amy E.	**216**	University City
Schmidt, Edwin H.	**190**	St. Louis
Schmidt, Edwin H., III	**190**	St. Louis
Schmidt, Herbert J.	**102**	Joplin
Schmidt, Jerome H.	**058**	Jefferson City
Schmidt, Kimberly	**216**	Chesterfield
Schmidt, Martin P.	**190**	St. Louis
Schmidt, Richard U., Jr.	**218**	Columbia
Schmidt, Stephen D.	**002**	St. Louis
Schmidt, Thomas L.	**125**	Kansas City
Schmitz, Christine M.	**218**	Columbia
Schmitz, John M.	**125**	Kansas City
Schmitz, Ralph A.	**166**	Monett
Schnake, Penelope J.	**216**	St. Louis
Schnarr, William	**189**	St. Charles
Schneider, Alan M.	**125**	Overland Park, KS
Schneider, J. Michael	**082**	Springfield
Schneider, Janel	**222**	Roeland Park, KS
Schneider, Paul G.	**190**	St. Louis

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*Doctor of Osteopathy

Schneider, Thomas A.	189	St. Charles
Schnidman, Jacquelyn C.	190	St. Louis
***Schnur, David**	042	Cape Girardeau
Schnurr, Thomas C.	058	Jefferson City
Schoedinger, George R., III	190	St. Louis
Schoenberger, John R.	042	Cape Girardeau
Schoenecker, Perry L.	190	St. Louis
***Schoenfeld, Roger H.**	102	Joplin
Schoengarth, Lowell D.	026	Columbia
Schoentag, Diane J.	014	Mexico
Schokker, Johannes	002	Jefferson City
Schoofs, Alexander	220	Kansas City
Schoolman, Arnold	125	Shawnee Mission, KS
Schopp, Alvin C.	190	St. Louis
Schottman, Gerhard W.	125	Shawnee Mission, KS
Schrenk, Loren C.	190	St. Louis
Schroder, William	125	Kansas City
Schroeder, Candena L.	218	Columbia
Schroeder, Jason	216	St. Louis
Schroeder, Walter A., Jr.	042	Cape Girardeau
Schroer, William C.	190	Bridgeton
Schroff, Carle E.	082	Springfield
Schroyer, Thomas M., Jr.	220	Kansas City
Schuepbach, Amy	220	Chesterfield
Schuessler, Edward C.	190	St. Albans
Schuessler, Wolfgang P.	190	St. Louis
Schuetz, Evelyne G.	189	St. Charles
Schuh, Marlys E.	190	Creve Coeur
Schultz, Earl R.	190	St. Louis
Schultz, Paul K.	190	St. Louis
Schultz, Scott	218	Columbia
Schulz, Richard C.	190	St. Louis
Schutte, Martin P.	216	St. Louis
Schuval, David	190	St. Louis
Schwartz, Howard I.	125	Kansas City
Schwartz, Howard R.	082	Springfield
Schwartz, I. David	125	Kansas City
Schwartzman, Neil R.	115	Lebanon
Schwarze, Daniel J.	190	St. Louis
***Schwarze, Robert F.**	190	Florissant
Schwedt, Todd J.	218	Columbia
Schwegler, Robert G.	125	Shawnee Mission, KS
Schweiss, John F.	190	St. Louis
Sciortino, Robert A.	190	Bridgeton
Scodary, Daniel J.	190	Bridgeton
Scoles, Lyndell D.	026	Columbia
Scott, Benn L.	042	Cape Girardeau
Scott, C. Alan	198	Marshall
Scott, E. David	058	Bonnots Mill
Scott, Jamie A.	082	Springfield
Scott, Joni C.	082	Rogersville
Scott, Kenneth F.	086	Clinton
Scott, Michael R.	082	Springfield
Scott, Robert W.	082	Springfield
Scott, Wendell J.	082	Springfield
Scowley, John E.	118	Richmond
Scroggins, Larry A.	026	Columbia
Scully, Thomas F.	190	St. Louis
Seabaugh, Janice L.	042	Cape Girardeau
Seabaugh, William L.	042	Cape Girardeau
Seaberg, John J., III	026	Columbia
Seagrave, Richard A.	082	Springfield
Sedgwick, William G.	190	St. Louis
See, W. Mike	026	Columbia
Seeley, James J.	190	St. Louis
Segall, Stephen A.	034	Poplar Bluff
Segraves, Steven D.	125	Kansas City
Seitz, Elson F.	125	Independence
Selhorst, John B.	190	St. Louis
Selke, Kenneth G.	190	Chesterfield
Sengelmann, Roberta D.	190	St. Louis
Serraiocco, Gina	222	St. Louis
Sertl, George O.	190	St. Louis
Sertl, James F.	190	St. Louis
Sessions, Donald G.	190	St. Louis
Severance, Michael S.	058	Jefferson City
Sevier, Cia-Mattae	220	Kansas City
Shaeffer, James T.	082	Springfield
Shagets, Frank W.	102	Joplin
Shah, Anwar	190	Chesterfield
Shah, Bharat	082	Springfield
Shah, Chirag V.	220	Kansas City, KS
Shah, Jitendra P.	190	St. Louis
Shah, Ramesh R.	102	Joplin
Shah, Riaz H.	014	Mexico
Shah, Sonal	222	St. Louis
Shah, Tejas	220	Kansas City, KS
Shaheen, Eleanor	026	Columbia
Shalet, Malcolm F.	125	Kansas City
Shanahan, Mary P.	102	Joplin
Shanahan, Philip J.	190	St. Louis
Shands, Courtney, III	190	St. Louis
Shane, Ramon A.	082	Springfield
Shaner, Thomas P.	190	St. Louis
Shank, Robert E.	190	St. Louis
Shapero, James A.	026	Columbia
Shapleigh, John B., II	002	Chesterfield
Shaplin, Alfred D.	106	Ballwin
Sharlow, Joseph W.	174	Ste. Genevieve
Sharma, Vidya	125	Kansas City
Sharp, John R.	125	Shawnee Mission, KS
Sharp, Ronald J.	125	Overland Park, KS
Shashek, Jennifer	216	St. Louis
Shatz, Burton A.	190	St. Louis
Shaw, Edward J.	190	St. Louis
Shaw, James T.	207	Hermann
Shaw, Richard C.	190	St. Louis
Shaw, Robert D.	206	Willow Springs
Shaw, Tania	222	St. Louis
Shea, James G.	207	Hobe Sound, FL
Shealy, C. Norman	082	Fair Grove
Shearer, Robert D.	058	Jefferson City
Shechter, Nathan	125	Overland Park, KS
Sheehan, Daniel J.	222	St. Louis
Sheehan, Maureen H.	125	Overland Park, KS
Sheehan, Michael B.	125	Kansas City
Sheehan, Paul J.	190	Bridgeton
Shelden, Russell D.	125	Kansas City
Sheldon, John M.	125	Kansas City
Shelley, James M.	082	Springfield
Shelley, William C.	002	Blue Springs
Shelton, Chad C.	218	Columbia
Shelton, Earl W.	190	Lake St. Louis
Shelton, R. Wayne	082	Springfield
Shen, Anthony S.	190	St. Louis
Shen, Jerome T.	190	St. Louis
Shen, Mark	226	Cape Girardeau
Shen, Winston W.	190	St. Louis

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Shepard, Matthew D.	**042**	Cape Girardeau
Sher, Allyn L.	**026**	Columbia
Sheridan, John J.	**190**	St. Louis
Sherman, David M.	**082**	Springfield
Sherman, W. Gary	**190**	Chesterfield
Sherrill, Joseph E.	**190**	St. Louis
Sherrod, Duane W.	**102**	Joplin
***Sherrod, Glenn M.**	**190**	Bridgeton
Sherwin, Charles S.	**190**	St. Louis
Shields, John B.	**190**	St. Louis
Shields, Lawrence S.	**082**	Springfield
Shifrin, Alexander	**125**	Kansas City
Shih, Marianne	**222**	Potomac, MD
Shih, Robert	**222**	St. Louis
Shimoda, Kumiko T.	**002**	Chesterfield
Shindel, Alan W.	**222**	St. Louis
Shine, Nichole M.	**218**	Columbia
Shine, Thomas E.	**190**	St. Louis
Shinn, Michael E.	**050**	Kansas City
***Shipman, Wade M.**	**082**	Rogersville
Shipton, Linda	**218**	St. Louis
Shireman, Frances	**125**	Kansas City
Shitut, Ravindra V.	**190**	St. Louis
Shniter, Lorinna	**190**	St. Louis
Shopper, Moisy	**190**	St. Louis
Shore, Jeffrey L.	**102**	Joplin
Short, Charles D.	**190**	St. Louis
Short, Howard N.	**207**	Washington
Shoults, Nicholas F.	**082**	Springfield
Shriver, Rebecca L.	**126**	Kansas City, KS
Shroff, Divya	**220**	Kansas City
Shroff, Kumkum	**190**	St. Louis
Shukla, Roshni	**218**	Columbia
Shuler, Frederick N.	**125**	Kansas City
Shull, G.D.	**058**	Jefferson City
Shultz, Thomas M.	**082**	Springfield
Shuss, David H.	**125**	Kansas City
Shuter, Eli	**190**	St. Louis
Sicat, Alfonso V.	**110**	Warrensburg
Siddiqui, Navid S.	**138**	Ellington
Siddiqui, Sameer A.	**218**	Columbia
Sides, Stanley D.	**042**	Cape Girardeau
Siegel, Barry A.	**190**	St. Louis
Siegel, Carl D.	**125**	Kansas City
Siegel, Charles	**050**	Gladstone
Siemer, Deanna M.	**042**	Jackson
Siemers, George E.	**190**	Naples, FL
Sigmund, Charles A.	**190**	Bridgeton
Sikka, Neal K.	**222**	St. Louis
Siler, Thomas M.	**189**	St. Charles
***Sill, William**	**189**	St. Peters
Silliman, York E.	**030**	St. Joseph
Silsby, Harry D.	**082**	Springfield
Silver, Bernd	**190**	St. Louis
Silvers, L. Michael	**125**	Kansas City
Silverstein, Randy B.	**190**	St. Louis
Silverstein, Steven M.	**125**	Kansas City
Simmons, Connie D.	**042**	Cape Girardeau
Simmons, Donald D.	**125**	Kansas City
Simmons, Jess S.	**102**	Joplin
Simmons, Natasha C.	**216**	St. Louis
Simmons, Nicholas R.	**218**	Columbia
Simon, David L.	**190**	St. Louis
Simon, Nathan M.	**190**	St. Louis
Simon, Sanford	**125**	Shawnee Mission, KS
Simowitz, Fredric M.	**189**	St. Charles
Simpson, Albert P.	**082**	Springfield
Simpson, Joseph R.	**190**	St. Louis
Sincox, Charles H.	**207**	Washington
Singh, Daljeet R.	**118**	Higginsville
Singh, Kuldeep	**046**	Macon
Singleton, Charles M., II	**125**	Kansas City
Singleton, Marvin A.	**102**	Joplin
Sirintrapun, Sahussapont	**218**	Columbia
Siripipat, Pallop	**014**	Mexico
Siriwangchai, Kulnarin G.	**126**	Kansas City, KS
Sirridge, Marjorie J.	**125**	Kansas City
Sislen, Donald R.	**190**	St. Louis
Sisson, Richard G.	**190**	St. Louis
Sistrunk, William W.	**082**	Springfield
Sitzman, Everette T.	**125**	Kansas City
Sivarajan, Subramanian	**125**	Kansas City
Sjoblom, Beth A.	**218**	Columbia
Skelley, Mark J.	**102**	Joplin
Skillman, Robert K.	**125**	Shawnee Mission, KS
Skimming, W. Lee	**190**	Glencoe
Skinner, Jocele A.	**216**	St. Louis
Skinner, John S.	**190**	Chesterfield
Sklenar, Donald E.	**030**	St. Joseph
Skolnick, David G.	**125**	Kansas City
Skoultchi, Alan J.	**195**	Ballwin
Slagle, Genelle J.	**126**	Merriam, KS
Slahorek, George J.	**030**	St. Joseph
Slankard, J. Edward	**125**	Leawood, KS
Slaughter, Carl R.	**050**	Morrilton, AR
Slaughter, James R.	**026**	Columbia
***Slavek, Thanh H.**	**206**	West Plains
Slentz, Edwin L.	**125**	Shawnee Mission, KS
Slocum, Stephen G.	**190**	St. Louis
Sly, Anne K.	**125**	Kansas City
Small, Jeffrey B.	**216**	St. Louis
Smalley, Stephen R.	**125**	Kansas City
Smalling, Ronnie G.	**002**	Springfield
Smeltzer, Frederick M.	**120**	Osage Beach
Smiley, William L.	**190**	St. Louis
Smith, Arthur B.	**125**	Philadelphia, PA
Smith, Bonnie R.	**218**	Columbia
Smith, Brenda S.	**125**	Kansas City
Smith, Brian	**126**	Kansas City, KS
Smith, Bruce D.	**030**	St. Joseph
***Smith, C. Daniel**	**030**	St. Joseph
***Smith, Charles H.**	**050**	Gladstone
Smith, Claude F.	**206**	Willow Springs
Smith, Courtland P., Jr.	**070**	Kennett
Smith, David Lambuth	**125**	Kansas City
Smith, Dermott A.	**190**	St. Louis
Smith, Emily L.	**190**	St. Louis
Smith, Gilbert D.	**034**	Poplar Bluff
Smith, Hubert E.	**125**	Kansas City
Smith, Hugh R.	**190**	St. Louis
Smith, Jared B.	**216**	St. Charles
Smith, Katherine W.	**125**	Shawnee Mission, KS
Smith, Kathleen	**190**	DuQuoin, IL
Smith, Kenneth B.	**207**	Washington
Smith, Kenneth G.	**190**	St. Louis
Smith, Kenneth R.	**206**	Bolivar
Smith, Kenneth R., Jr.	**190**	St. Louis
Smith, Laura	**216**	Palo Alto, CA

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*Doctor of Osteopathy

Smith, Michael	222	St. Louis
Smith, Patrick A.	026	Columbia
Smith, Peter G.	190	St. Louis
Smith, Porter	070	Poplar Bluff
Smith, Rebecca A.	222	St. Louis
Smith, Robert W.	190	St. Louis
Smith, Roland T.	102	Gulfport, MS
Smith, Sally L.	190	Chesterfield
Smith, Stephen R.	190	St. Louis
Smith, Timothy W.	125	Kansas City
***Smith, Toni R.**	148	Kirksville
Smith, W. Russell	102	Carthage
Smith, Wallace B.	125	Independence
Smith, William J.	086	Windsor
Smoller, Martin B.	189	St. Louis
Snead, William H.	082	Springfield
Sneid, David S.	125	Kansas City
Snow, Emasue	082	Springfield
Snow, Jerry W.	218	Malden
Snow, Jon F.	082	Springfield
Snowden, Kent L.	190	St. Louis
Snyder, Charles L.	125	Overland Park, KS
Sobky, George H.	190	St. Charles
Sobky, Kareem	190	St. Charles
Soha, Joseph J., Jr.	026	Columbia
Sohn, Richard	190	St. Louis
Solanki, Nareshkumar J.	190	Lake St. Louis
Sollars, Eric G.	030	St. Joseph
Solomon, Steven L.	190	Chesterfield
Sommer, Conrad S.	190	St. Louis
Soorya, Narendir T.	190	St. Louis
Sopuch, John A.	190	St. Louis
Sosna, Jacob P.	190	St. Louis
Soto, Albert A.	190	St. Louis
Soucy, John C.	189	St. Charles
Spadaro, James J.	190	St. Louis
Spadone, Donald P.	026	Columbia
Spaedy, Tony	026	Columbia
Spalding, David L.	082	Rogersville
Spalding, Wilber B., Jr.	125	Kansas City
Sparkman, Thomas C.	042	Cape Girardeau
Spearman, Michael L.	190	St. Louis
Spector, Gershon	190	St. Louis
Spehar, Pascal E.	125	Independence
Spence, Paul A.	042	Cape Girardeau
Spence, Robert	218	Rolla
Speno, Angelo A.	190	St. Louis
Spernoga, John F.	190	St. Louis
Spieldoch, Rachel L.	218	Columbia
Spitler, Allen L.	042	Cape Girardeau
Spitzfaden, Andrew	218	Columbia
Spivack, Alan R.	190	Chesterfield
Spollen, Linda E.	026	Columbia
Sponenberg, Don D.	082	Springfield
Sportsman, Weldon L.	050	Kansas City
Sprague, Gita	030	St. Joseph
Spurgat, Robert M.	030	St. Joseph
Spurgeon, Milo J.	026	Columbia
Spurgeon, Natalie	220	Kansas City
Spurgeon, Stephen	190	Maryland Heights
Spurling, Jason K.	218	Columbia
Spurlock, Luther D.	135	Rolla
Spurney, Joe E.	125	Kansas City
Spurny, Otto M.	125	Kansas City
Spurrier, Mark H.	190	St. Louis
Squire, Nancy A.	126	Raytown
Squitieri, Alphonse J.	190	St. Louis
Srivastava, Rashmi	218	Columbia
St. John, Donald R.	102	Marshall
St. Peter, David A.	126	Kansas City
Stafford, Walter R.	190	St. Louis
Stahl, Lloyd D.	125	Overland Park, KS
***Stahly, Randall L.**	042	Cape Girardeau
Stahr, William D.	042	Cape Girardeau
Stallard, Donald J.	030	St. Joseph
Stam, M. Denton	082	Springfield
Stamatis, John J.	082	Springfield
Stamps, Gregory S.	082	Springfield
Standiford, Steven B.	026	Columbia
Stanley, Brad K.	125	Independence
Stanley, Charles G.	125	Kansas City
Stanley, John O.	050	Kansas City
Stanton, Liza S.	002	O'Fallon
Stark, Karl R.	125	Kansas City
Starke, Joe D.	026	Columbia
Starke, Keith M.	002	St. Louis
Starks, Gregory C.	125	Kansas City
Starr, Steven K.	125	N. Kansas City
Statland, Harry	125	Kansas City
Statland, Morris	125	Shawnee Mission, KS
***Steele, Brian K.**	102	Joplin
Steele, Jack T.	190	Bridgeton
Steele, Mark T.	002	Kansas City
Steenbergen, Michael	058	Jefferson City
Steer, Phyllis L.	002	Kansas City
Steffen, Lawrence F.	125	Shawnee Mission, KS
Steiling, Sylvia A.	190	St. Louis
Stein, Bernard	102	Joplin
Steinberg, Franz U.	190	St. Louis
***Steinberg, Lee M.**	050	Kansas City
***Steinbrecher, Janis M.**	125	Lee's Summit
Steiner, Alexander J.	190	St. Louis
Steiner, Marvin P.	125	Independence
Steinhaus, David M.	125	Kansas City
Stelmach, Walter J.	125	Kansas City
Stengel, Robyn M.	218	Chesterfield
Stephen, C. Ronald	190	Chesterfield
Stephenson, Hugh E.	026	Columbia
Stephenson, William T.	125	Kansas City
Sterkel, Barbara B.	190	St. Louis
Sterkel, Richard L.	190	St. Louis
Sterling, Kevin	222	St. Louis
Stevens, Amy E.	218	Columbia
Stevens, Bobby A.	224	Overland Park, KS
Stevens, Edward M.	030	St. Joseph
Stevens, Sheridan	125	Independence
Stevens, Tracy L.	125	Kansas City
Stewart, Angela R.	026	Columbia
Stewart, Harry A.	125	Kansas City
Stewart, James L.	050	Kansas City
Stewart, L. Paul	190	St. Louis
Stewart, Robert B.	082	Springfield
Stickle, Arthur W.	190	St. Louis
Stickley, Louis P.	190	St. Louis
Stiers, Julaine	026	Columbia
Stiles, Michael C.	125	Kansas City
***Stillie, G. Donald**	125	Kansas City
Stinnett, D. Mitchell	102	Joplin

Alphabetical Roster (as of 6/30/99)

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*Doctor of Osteopathy

Stith, John A. 190
St. Louis
Stockton, Raymond W. 125
Shawnee Mission, KS
Stockwood, Robert C. 178
Sedalia
Stoecker, Willeford J. 042
Cape Girardeau
Stoecker, William V. 135
Rolla
Stoffa, Maureen E. 190
St. Louis
Stohr, Paul E. 190
St. Charles
Stokes, Douglas L. 030
St. Joseph
Stokes, James M. 190
St. Louis
Stolar, Cary G. 195
St. Louis
Stoliar, John B. 190
St. Louis
Stone, Carissa M. 002
Kansas City
Stoneman, William, III 190
St. Louis
Stoops, Stephen L. 125
Independence
Stout, Carl N. 125
Independence
Stout, Tim 126
Lexington, KY
Stoy, Robert P. 026
Columbia
Stradford, H. Todd 026
Columbia
Stratemeier, Edward H. 125
Blue Springs
Straub, David L. 102
Joplin
Strauss, Carl F. 125
Kansas City
Streiff, Maria G. 190
St. Louis
Strevey, Tracy E., Jr. 002
Frontenac
Stricker, William E. 135
Rolla
Strickland, James C. 190
St. Louis
Stringer, Kenton L. 166
Aurora
***Stringer, Robert F.** 102
Joplin
Strobach, Kurt F. 190
St. Louis
Stromberg, Brent V. 190
St. Louis
Stronach, Linda L. 190
St. Louis
Strong, Alexandra J. 125
Kansas City
Stronsky, David 190
St. Louis

Stroud, Malcolm H. 190
Dallas, TX
Struttmann, Matthew 218
Columbia
Stryker, William I. 190
Osprey, FL
Stuart, Byron M. 026
Boonville
Stuart, Danl D. 046
Brunswick
Stuart, Wallace E. 190
Paradise Valley
Stuber, Robert R. 030
St. Joseph
Stuerman, Lawrence G. 150
Louisiana
Stufflebam, Robert E. 082
Springfield
Stuppy, Mark S. 082
Springfield
Stuppy, Mary F. 002
Springfield
Stuppy, Robert J. 102
Joplin
Sturm, Julie M. 220
Mission, KS
Sturtevant, Harwood N. 082
Springfield
Su, Philo S. 058
Jefferson City
Suarez, Alberto 125
Lee's Summit
Suarez-Solar, Pedro L., Jr. 190
St. Louis
Subbaiah, Kosuri V. 190
Ballwin
Subramanian, Geetha 218
Columbia
Subramanian, S. 102
Carthage
Sudekum, Anthony E. 189
Defiance
Sudekum, Joseph M. 190
St. Louis
Suedekum, Brandon 220
Kansas City
Sueper, Robert H. 190
St. Louis
Sugarbaker, Everett D. 058
Jefferson City
Sugarbaker, Stephen P. 058
Jefferson City
Suk, Debbie 218
Columbia
Sullivan, Andrea J. 126
Overland Park, KS
Sullivan, Christine 125
Overland Park, KS
Sullivan, Clement J. 190
St. Louis
Sullivan, Dan T. 082
Springfield
Sullivan, William W. 190
St. Louis

Sultan, Tipu 190
Florissant
Summers, John B. 190
St. Louis
Summers, Thomas F. 190
Olney, IL
Sun, Ann Marie 218
Springfield
Sun, Judy 220
Kansas City, KS
Sun, Yoong 222
St. Louis
Sunderji, Shiraz 190
St. Louis
Sundermeyer, Mark L. 218
Columbia
Sundstrom, Frank D. 082
Springfield
Sundt, Thoralf M. 002
St. Louis
Sunshine, Herbert 190
St. Louis
Suntharalingam, Mythili 222
St. Louis
Supattanasiri, Gultida J. 218
Columbia
Surana, Neeraj 222
St. Louis
Susa, Joe S. 226
Jackson
Suseela, Dasari 125
Kansas City
Susi, Jesse G. 190
St. Louis
***Suthoff, Jim** 102
Joplin
Sutphen, Eric J. 190
St. Louis
Suwannasri, Rudee 190
St. Louis
Svancarek, William P. 190
St. Louis
Swaim, Truett 125
Kansas City
Swaminathan, Rajesh 195
Ballwin
Swaney, Charles M. 026
Columbia
Swango, J. Scott 082
Springfield
Swartz, Janelle A. 218
Columbia
Swaykus, Bernard T. 190
Bridgeton
Sweeney, Thomas P. 002
Springfield
Sweeney, Thomas P. 082
Republic
Sweiger, James H. 054
Plattsburg
Swinfard, Ronald W. 026
Columbia
Switzner, Diane L. 082
Springfield

Sylvanovich, W. Richard 190
St. Louis
Szabados, Ernest D. 125
Independence
Szewczyk, Michael J. 026
Columbia
Szoko, Edward 190
St. Louis
Szymanski, Stanley R. 078
Wilmette, IL

T

Taban, Ryan 216
St. Louis
Tackitt, Bobby O., II 034
Poplar Bluff
Tadikamalla, Raghu 222
St. Louis
Taege, Alan J. 030
St. Joseph
Tailor, Chandrakant C. 190
St. Louis
Takacs, Robert J. 125
Kansas City
Takeshita, Junko 222
St. Louis
Talbert, Clifford R. 042
Cape Girardeau
Tamblyn, Claire L. 125
Tubac, AZ
Tandon, Mini 224
Kansas City
Tang, Teodoro 135
Salem
Taniguchi, Jennifer 222
Bloomington, MN
Tanner, John P. 125
Kansas City
Tanner, Robert H. 058
Jefferson City
***Tanner, Scott W.** 058
Jefferson City
Tanphaichitr, Kongsak 190
St. Louis
Tansuwan, Chukiat 190
St. Louis
Taormina, Marc K. 125
Independence
Tariq, Manzoor A. 190
Chesterfield
Tarsney, Sean P. 126
Kansas City
Tarvin, Randy J. 125
Lee's Summit
***Tarwater, James K.** 050
Kansas City
Tat, Nazhat 218
Columbia
Tataria, Monika 222
St. Louis
Tate, Kara L. 125
Kansas City

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*Doctor of Osteopathy

Tatini, Paparao	**002**	St. Louis
Tauber, Joseph	**125**	Prairie Village, KS
Taute, Hermann	**190**	St. Louis
Taylor, Amy M.	**218**	Columbia
Taylor, John R.W.	**125**	Independence
Taylor, Philip W.	**042**	Cape Girardeau
Taylor, Steve J.	**014**	Mexico
Taylor, William K.	**082**	Springfield
Teague, J. Lynn	**026**	Columbia
Tedrow, Jeffrey R.	**066**	Bolivar
Teeter, Rayni L.	**218**	Columbia
Teff, Richard J.	**027**	Columbia
Tegeler, Kent E.	**050**	Liberty
Tegtmeyer, Chris	**115**	Lebanon
Tekwani, Hiralal T.	**190**	St. Louis
Tellerman, Barbara J.	**026**	Columbia
Templer, Jerry W.	**026**	Columbia
Tendai, Mark M.	**082**	Springfield
Tenorio, Arturo A.	**158**	Stanberry
Tenorio, Genoveva	**158**	Albany
Teoh, JoAnne H.	**216**	Brentwood
Tepper, Arnold	**190**	St. Louis
Tepper, Micah	**218**	Columbia
Tergin, Helen F.	**218**	Columbia
***Terpstra, Gregory K.**	**138**	Potosi
Terry, Boyd	**026**	Columbia
Terry, James F.	**082**	Springfield
Terry, James W.	**042**	Cape Girardeau
Terry, Melissa V.	**218**	Columbia
Terschluse, David A.	**190**	Bridgeton
Tess, Allen F.	**190**	Florissant
Tessier, John E.	**190**	St. Louis
Tevaarwerk, Amye'	**222**	St. Louis
***Tewis, Huey D.**	**042**	Cape Girardeau
Thahane, Lineo	**222**	St. Louis
Thal, Sanford M.	**190**	St. Louis
Thalblum, Harvey	**125**	Kansas City
Thale, Thomas R.	**190**	St. Louis
Thanawalla, Shaukat A.	**014**	Mexico
Tharenos, Christy	**027**	Columbia
Thawley, Stanley E.	**190**	St. Louis
Thedinger, Bradley S.	**125**	Kansas City
Theel, Otto W., Jr.	**125**	Shawnee Mission, KS
Thesing, John A.	**125**	Lenexa, KS
Thibeault, Donald W.	**125**	Kansas City
Thiel, J. Allen	**190**	St. Louis
Thiele, Belmont R.	**190**	Las Vegas, NV
Thiele, Otto K.	**189**	St. Charles
Thierauf, Charles G.	**002**	St. Louis
Thies, Jerome H.	**214**	Osceola
Thom, William H.	**216**	St. Louis
Thoma, George E., Jr.	**190**	St. Louis
Thomas, Alexis G.	**125**	Kansas City
Thomas, Christopher Y.	**125**	Shawnee Mission, KS
Thomas, Deborah G.	**042**	Cape Girardeau
Thomas, Elizabeth H.	**125**	Kansas City
Thomas, F. Anthony	**050**	Kansas City
Thomas, Horace E.	**026**	Columbia
Thomas, J. Regan	**190**	St. Louis
Thomas, James J.	**125**	Kansas City
Thomas, Jonathan L.	**042**	Cape Girardeau
Thomas, Leslie D.	**050**	N. Kansas City
Thomas, Lisa A.	**027**	Columbia
Thomas, Matthew A.	**190**	St. Louis
***Thomas, Norvin E.**	**014**	Mexico
Thomas, Robert M.	**026**	Columbia
Thomasson, David D.	**082**	Springfield
Thomasson, Jeffrey L.	**190**	St. Louis
Thomasson, Mary W.	**190**	St. Louis
Thompson, David E.	**125**	Lee's Summit
Thompson, F. Gregg	**030**	St. Joseph
Thompson, Frederick E.	**050**	Liberty
Thompson, James E.	**206**	West Plains
Thompson, M. Bryant	**190**	Chesterfield
Thompson, Paul D.	**042**	Cape Girardeau
Thompson, Randall C.	**125**	Shawnee Mission, KS
Thompson, Robert F.	**125**	Kansas City
Thompson, Robert H.	**216**	St. Louis
Thomson, William M.	**190**	Chesterfield
Thornburg, Matt E.	**218**	Columbia
Thorne, Marc	**222**	St. Louis
Thornhill, Joseph M.	**190**	St. Louis
Thornton, Fred H.	**202**	Sikeston
Thornton, Michael K.	**106**	St. Peters
***Thornton, Russell J.**	**118**	Higginsville
Thorpe, William P.	**042**	Cape Girardeau
Threats, Susan C.	**190**	St. Louis
Threlkeld, Kevin L.	**002**	Lake St. Louis
Throgmorton, Shawna I.	**216**	St. Louis
Throne, Ben J.	**125**	Gig Harbor, WA
Thyssen, Erik P.	**190**	St. Louis
Tice, Wayne K.	**125**	Lee's Summit
Tichenor, Robert W.	**190**	Fenton
Tiefenbrunn, Sharon F.	**190**	St. Louis
Tiemann, James H.	**002**	Lee's Summit
Tietjen, Fred O.	**120**	Osage Beach
Till, Bennie N.	**034**	Poplar Bluff
Tillema, David A.	**125**	Kansas City
Tilley, Ann	**222**	St. Louis
Tillman, Mary A.	**190**	St. Louis
Tilzer, Seth	**190**	Florissant
Timothy, Jeremy S.	**216**	St. Louis
Tindall, Robert N.	**190**	Spirit Lake, IA
Ting, Matthew H.	**082**	Springfield
Tinsley, John C.	**026**	Columbia
Tiojanco, Milagros E.	**125**	Kansas City
Tippett, Jack C.	**190**	St. Louis
Tittel, Paul D.	**222**	Colby, KS
Titterington, Frank W.	**125**	Kansas City
Tjandra, Sarikun	**126**	Roeland Park, KS
Tobey, Albro C., Jr.	**190**	St. Louis
Tobin, Gregory A.	**042**	Cape Girardeau
Tobin, Marla J.	**110**	Warrensburg
Tobin, Robert F.	**030**	St. Joseph
Tobler, Jerry	**190**	Ballwin
Tobler, Randall W.	**190**	St. Louis
Tompson, Richard G.	**206**	West Plains
Tompson, Robert V.	**046**	Moberly
Tonnes, Alicia M.	**216**	Manchester
Torontow, R. John	**214**	Nevada
Torrence, Ralph J.	**190**	Chesterfield
Tosh, Aneesh K.	**218**	Columbia
Totty, William G.	**190**	St. Louis
Toubes, Daniel B.	**125**	Kansas City
Towery, Derek S.	**102**	Joplin
Towle, Dana R.	**050**	N. Kansas City
Toy, Karen L.	**178**	Sedalia
Trammell, Lee W.	**026**	Columbia

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Traub, Michael	216	St. Louis
Trendle, Michael C.	058	Jefferson City
Trentham, Orin P., III	102	Joplin
Trikha, Ajit	002	Cahokia, IL
Trimble, Christopher P.	126	Overland Park, KS
Trimble, George X.	125	Kansas City
Trinidad, Hermanito R.	078	Chillicothe
Triplett, Daniel A.	050	Liberty
Triska, Roland A.	190	St. Louis
Tritt, Kelley L.	218	Columbia
Tritz, Denise M.	058	Jefferson City
Troop, Bryan R.	190	St. Louis
Trotta, Philip C.	190	St. Louis
Trotter, Francis O., Jr.	190	Carrollton
Trotter, W. Yates	082	Springfield
Troxil, Elizabeth B.	082	Springfield
True, John H.	034	Poplar Bluff
Trueblood, Michael C.	042	Cape Girardeau
Trugly, Edith S.	190	St. Louis
Trumbower, William D.	026	Columbia
Truog, William E.	125	Kansas City
Trygg, Kelly A.	066	Bolivar
Tsang, John L.	082	Las Vegas, NV
Tuck, Janna M.	042	Cape Girardeau
Tucker, Dolores R.	190	Chesterfield
Tucker, George L.	002	Town & Country
Tucker, Leslie E.	207	Washington
Tucker, Robert E.	190	St. Louis
Tungesvik, Mark M.	218	Jefferson City
Tuohy, Gerald F.	125	Leawood, KS
Tupper, Joel	102	Joplin
Turano, William L.	125	Raytown
Turfboer, Robert	102	Tarboro, NC
Turgeon, Ronald P.	190	St. Louis
Turnbaugh, Thomas R.	058	Jefferson City
Turner, Glenn O.	082	Springfield
Turner, James D.	207	Washington
Turner, Jane W.	195	St. Louis
Turner, Kirby L.	034	Poplar Bluff
Turner, Lanny M.	190	St. Louis
Turner, Michael L.	034	Poplar Bluff
***Turner, Timothy T.**	002	Barrington, IL
Turner, William A.	214	Nevada
***Turpin, F. Duane**	190	Bridgeton
Tutar, Ali	126	Daly City, CA
Tuttle, Jay F.	138	Creve Coeur
Twyman, Michael	216	St. Louis
Tygett, Jos N.	042	Cape Girardeau

U

Uhlemann, John H.	189	St. Charles
Uhlemeyer, Henry A.	190	St. Louis
Uhrig, Jack R.	198	Marshall
Uketui, Ozoemenam I.	030	St. Joseph
Ulbrich, Jamie G.	198	Marshall
***Umfleet, Jeffrey C.**	042	Cape Girardeau
Underwood, Dick H.	125	Leawood, KS
Underwood, Johnson, III	050	N. Kansas City
Unger, Benjamin D.	222	St. Louis
Ungvari, Joseph C.	190	St. Louis
Unterman, Steven R.	125	Kansas City
Unwin, Donald R.	190	St. Louis
Uy, Geoffrey	222	St. Louis

V

Vacca, Joseph B.	190	St. Louis
Vajaranant, Manit	118	Lexington
Vale, Janie R.	026	Columbia
Vallurupalli,Vijayalakshmi	190	Bridgeton
Valuck, Richard P., Jr.	150	Hannibal
VanAmburg,Albert L., III	190	Chesterfield
Van Biber, James T.	125	Independence
Van Buskirk, William C.	125	Shawnee Mission, KS
Van Dyke, Elmer H.	178	Sedalia
Van Norman, Robert T.	190	St. Louis
Van Ryn, Jacques S.	190	Bridgeton
Van Way, Charles W., III	125	Kansas City
Van Zanten, Niko A.	214	Osceola
Vandenbrul, Robin L.	218	Columbia
Vandewalker, Mark L.	026	Columbia
Vandivort, Paul M., Jr.	190	St. Louis
Vandover, John T.	190	St. Louis
Vanriessen, James E.	218	Columbia
VanGoidsenhoven, Guy E.	190	St. Louis
VanVoorn, Catherine M.	026	Columbia
Vaporean, Mark L.	026	Columbia
Vargas, Teodoro C.	190	Pacific
Varma, Devendra K.	034	Poplar Bluff
Vas, Wenzel G.	190	St. Louis
Vaslow, Dale F.	058	Jefferson City
Vaughn, James W.	125	Overland Park, KS
Veitch, John M.	102	Joplin
Velander, Robert D.	125	Blue Springs
Velasco, Ernesto T.	190	St. Louis
Vellek, Mark J.	026	Columbia
Vemulakonda, Guranadh A.	222	St. Louis
Venneman, Charles R.	125	Kansas City
Verde, Julian N.	190	St. Louis
Verdine, Benjamin W.	222	St. Louis
Vergara, Gerardo G.	125	Kansas City
Vermont, Sharon D.	002	St. Louis
***Verstraete, John C.**	126	Kansas City
Verzola, Eufemio G.	106	Herculaneum
Vest, James C.	190	Chesterfield
Vetsch, Raymond	102	Joplin
***Vialle, Gene M.**	125	Kansas City
Viamontes, Jorge A.	190	St. Louis
Vibulakaopun, Pairat	138	Bonne Terre
Vickar, Garry M.	190	Florissant
Vierling, Stephen E.	190	St. Louis
Viero, Laura M.	216	St. Louis
Vierra, Michael J.	120	Osage Beach
Viers, Wayne A.	190	St. Louis
Vierthaler, Mary E.	126	Olathe, KS
Vietti, Teresa J.	002	Creve Coeur
Vijungco, Jose G.	190	St. Louis
Villafuerte, Nila A.	190	St. Louis
Villahermosa, Juanito L.	010	Savannah
Villamar, Elizabeth N.	190	St. Louis
Villanueva, Angela A.	125	Overland Park, KS
Villarama, Antonio P.	190	St. Louis
Vilmer, Charles E.	050	Polo
Vilmer, Stephen E.	050	N. Kansas City
Viril, Leonardo C.	125	Kansas City
Vitale, Anthony J.	190	Chesterfield
Vitale, Stephen J.	190	Chesterfield
Vitale, Thomas J., Jr.	190	St. Louis
Vivian, Gary D.	189	St. Louis
Viviano, Joseph G.	190	Glendale
Vo, Thuy-Lieu T.	190	St. Louis
Voelker, Donald J.	026	Columbia

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Vogel, Curt M.	**026**	Columbia
***Vogelsang, Judith K.**	**125**	Kansas City
Vogt, Douglas	**026**	Columbia
Vogt, Eric I.	**218**	Columbia
Vos, Jeremy	**222**	St. Louis
Voszler, Richard B.	**042**	Cape Girardeau
Voth, Harold W.	**125**	Shawnee Mission, KS

W

Wachter, Ronald M.	**082**	Springfield
Wade, Kim C.	**125**	Kansas City
Wade, Scott A.	**030**	St. Joseph
Wadle-Wignall, Stephanie	**126**	Kansas City
Wadley, Jeff	**178**	Sedalia
Wadlow, Ernest E.	**030**	Phoenix, AZ
Wadsworth, Deborah T.	**190**	St. Louis
Waeckerle, Joseph F.	**125**	Leawood, KS
Wagan, Primitiva C.	**190**	St. Louis
Waggoner, Charles M.	**026**	Columbia
Waggoner, Sharon E.	**030**	St. Joseph
Wagner, Daniel G.	**190**	Chesterfield
Wagner, Hope	**218**	Rocheport
Wagner, Jason M.	**218**	Columbia
Wagner, John R.	**190**	St. Louis
Wagoner, Chad	**218**	Columbia
Waheed, Shahid	**014**	Mexico
Wakefield, Mark R.	**027**	Columbia
Wakeman, Newt, Jr.	**082**	Springfield
Wald, Stanley M.	**190**	St. Louis
Walden, David T.	**002**	St. Louis
Walden, James M.	**125**	Kansas City
Waldman, Zev L.	**222**	St. Louis
Waldo, John P.	**042**	Cape Girardeau
Waldrop, Devin V.	**216**	Brentwood
Waldrop, Kevin L.	**216**	Brentwood
Waldschmidt, Mike L.	**125**	Liberty
Walentik, Corinne	**190**	St. Louis
Walker, Francis S.	**190**	St. Louis
Walker, Gary K.	**082**	Springfield
Walker, Gregory E.	**125**	Independence
Walker, Harvey, Jr.	**190**	St. Louis
Walker, J. Clinton	**222**	St. Louis
Walker, J. Leslie	**190**	St. Louis
Walker, Melvin O., Jr.	**082**	Springfield
Walker, Orville C.	**125**	Independence
Walker, Randal E.	**190**	St. Louis
Walker, William M.	**082**	Rogersville
Wall, Harry C.	**125**	Shawnee Mission, KS
Wall, Joe A.	**206**	Houston
Wall, Leonard A.	**125**	Shawnee Mission, KS
Wall, Norman R.	**082**	Springfield
Wallace, Darryl L.	**125**	Kansas City
Wallace, Erik	**222**	St. Louis
Wallace, Ernest M.	**218**	Columbia
Walley, Lynn J.	**150**	Hannibal
Walline, T. Andrew	**125**	Prairie Village, KS
Walls, Joseph T.	**026**	Columbia
Walls, Kelvin	**125**	Independence
Walsh, Barbara A.	**190**	St. Louis
Walsh, James W.	**190**	St. Louis
Walsh, Mark	**222**	St. Louis
Walsh, Rhonda M.	**218**	Columbia
Walsh, Richard J.	**030**	St. Joseph
Walters, Frederick P.	**190**	St. Louis
***Walton, Frank C.**	**206**	Winona
Walz, Bruce J.	**190**	St. Louis
Wan, Shaw P.	**135**	Rolla
Wang, Helena H.	**058**	Jefferson City
Wang, Leo H.	**222**	St. Louis
Wankum, Robert P.	**058**	Jefferson City
Wantuck, Donald K.	**082**	Springfield
Ward, Brian W.	**218**	Columbia
Ward, Christina M.	**222**	St. Louis
Ward, Dana S.	**026**	Columbia
Ward, Joe W.	**042**	Cape Girardeau
Ward, Mark R.	**082**	Springfield
Wardell, M. Annette	**082**	Springfield
Waring, J. Michael	**125**	Kansas City
Warren, Ronda Lynn	**125**	Kansas City, KS
Warwick, Marion C.	**058**	Jefferson City
***Wasserman, Gary S.**	**125**	Kansas City
Wasserman, Mark S.	**190**	St. Louis
Waterfield, Jim R.	**082**	Springfield
Waterman, Franklin M.	**050**	Liberty
Waters, Hugh R.	**190**	Chesterfield
Wathanacharoen, Suchint	**125**	Kansas City
Watkins, George L.	**138**	Rancho Santa Fe, CA
Watson, Michael E., Jr.	**218**	Columbia
Watson, R. Alan	**030**	St. Joseph
Watson, Timothy B.	**026**	Columbia
Watson, Trevor F.	**026**	Columbia
Watters, John L.	**224**	Kansas City
Watts, Byron E.	**058**	Jefferson City
Watts, Samuel M.	**166**	Mt. Vernon
Wax, Martin B.	**190**	St. Louis
Waxelman, Roger J.	**190**	Ballwin
Waxman, Jane Z.	**125**	Lenexa, KS
Waxman, Joel E.	**082**	Springfield
Wayne, Sherwyn J.	**190**	St. Louis
Wear, Desha C.	**216**	St. Louis
Weaver, Jason A.	**216**	Omaha, NE
Weaver, Mark E.	**082**	Springfield
***Webb, James J.**	**102**	Joplin
Webb, John M.	**125**	Kansas City
Webb, Paul B., Jr.	**190**	St. Louis
Weber-Bornstein, Nancy	**042**	Cape Girardeau
Weeks, Amanda	**222**	St. Louis
Weick, Raymond	**218**	Columbia
Weide, Allan R.	**050**	N. Kansas City
Weidt, Laura N.	**218**	Columbia
Weiford, Edward C.	**125**	Shawnee Mission, KS
Weigand, Robert T.	**030**	St. Joseph
Weinand, Ernest E.	**030**	Tucson, AZ
Weinstein, Charles L.	**125**	Kansas City
Weinstein, David L.	**190**	St. Louis
Weinstein, Stephen H.	**026**	Columbia
Weinstock, Leonard B.	**190**	St. Louis
Weir, Robert K.	**125**	Kansas City
Weis, Ronald R.	**125**	Leawood, KS
Weise, Marc W.	**190**	Santa Maria, CA
Weiser, Laurie D.	**218**	Grosse Pointe, MI
Weiss, Howard	**190**	St. Louis
Weiss, James J.	**058**	Jefferson City
Weiss, James M.	**026**	Columbia
Weiss, Peter D.	**190**	St. Louis
***Weiss, Randy B.**	**102**	Joplin
Weiss, Stuart	**190**	St. Louis
Welch, Kristen I.	**222**	St. Louis
Weldon, Virginia V.	**190**	St. Louis

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*Doctor of Osteopathy

Weltmer, John B., Jr.	**190**	St. Louis
Welton, Stephen T.	**202**	Sikeston
Wempe, George R.	**158**	Rio Verde, AZ
Wempe, Michael J.	**030**	St. Joseph
Wentworth, Nicole L.	**126**	Kansas City, KS
Werner, Caroline A.	**190**	Florissant
Werner, Dean F.	**050**	Kansas City
Werner, F. Scott	**050**	N. Kansas City
Werner, Jason	**218**	Columbia
Werner, William A.	**190**	St. Louis
Werth, Joseph A.	**058**	Jefferson City
***Wescott, Thomas P.**	**110**	Holden
West, Harold D.	**125**	Independence
West, William T.	**218**	Columbia
Westcott, Bruce R.	**042**	Cape Girardeau
Westerfeld, Roy A.	**189**	St. Charles
Westerman, Robert N.	**190**	St. Louis
Westfall, Scott G.	**190**	Chesterfield
Westfall, Susan H.	**190**	St. Louis
Westgate, Steven J.	**026**	Columbia
Westrich, David J.	**042**	Cape Girardeau
Wethers, Darren E.	**190**	St. Louis
Wetzel, C. Robert	**086**	Clinton
Wetzel, Gus S.	**086**	Clinton
Wexler, Stephen A.	**190**	St. Louis
Weyerich, Noel F.	**190**	St. Louis
Weyman, Philip J.	**190**	Chesterfield
Wheeler, Camilla A.	**058**	Jefferson City
Wheeler, Charles B.	**125**	Kansas City
Wheeler, Eden	**125**	Kansas City
Wheeler, Paul D.	**050**	Liberty
Wheeler, Robert L.	**214**	Harrisonville
Whitaker, James H.	**125**	Kansas City
White, Brad C.	**190**	St. Louis
White, Bruce I.	**190**	St. Louis
White, Charles H.	**125**	Shawnee Mission, KS
White, Eugene F.	**135**	Rolla
White, Frisco R.	**224**	Merriam, KS
White, Heather A.	**218**	Columbia
White, Newton B.	**190**	Town & Country
White, William L.	**125**	Kansas City
Whitener, Miles C.	**190**	St. Louis
Whitesell-Neely, Angie	**218**	Columbia
Whiteside, Leo A.	**190**	St. Louis
Whiting, Richard B.	**190**	St. Louis
Whitlock, C. Courtney	**082**	Springfield
Whitman, Daniel S.	**125**	Kansas City
Whitmore, J. Stewart	**125**	Washington, NC
Whittaker, Thomas J.	**125**	Kansas City
Whitten, J. Stephen	**042**	Cape Girardeau
Whitten, M. Foster	**102**	Carthage
Whittico, James M.	**190**	St. Louis
Wiant, James R.	**190**	St. Louis
Wible, Jerry C.	**082**	Springfield
Wice, Martin B.	**190**	St. Louis
Wichman, Jeffrey R.	**216**	St. Louis
Wicklund, Brian M.	**125**	Kansas City
Wieder, Richard H.	**190**	St. Louis
Wiegand, Herbert C.	**190**	St. Louis
Wiele, Kimberly N.	**190**	St. Louis
Wilbers, Raymond H.	**014**	Mexico
Wilbois, Ronald P.	**190**	St. Louis
Wilcox, Dennis M.	**125**	Leawood, KS
Wild, Alan P.K.	**190**	Chesterfield
Wilhite, Tria K.	**150**	Shelbyville
Wilkins, Michael S.	**125**	Kansas City
Wilkins, Thomas L.	**050**	Kansas City
Wilkinson, David	**190**	St. Louis
Wilkinson, Everett A.	**125**	Overland Park, KS
Wilkinson, Linda	**125**	Kansas City
Willcoxon, Robert L.	**102**	Joplin
Willey, Marianne	**222**	St. Louis
Williams, C. Mark	**125**	Kansas City
Williams, Carol F.	**190**	St. Louis
Williams, Craig W.	**042**	Cape Girardeau
Williams, Fred	**026**	Columbia
Williams, John W., IV	**002**	Springfield
Williams, Joseph	**190**	St. Louis
Williams, Kimberly	**222**	St. Louis
Williams, Paul A.	**125**	Kansas City
Williams, Paul A.	**002**	St. Louis
Williams, R. Jerome, Jr.	**190**	St. Louis
Williams, R. Jerome, Sr.	**190**	St. Louis
Williams, Rick W.	**082**	Ozark
Williams, Starks J.	**125**	Kansas City
Williams, Todd L.	**102**	Joplin
Williams, W.A., Jr.	**042**	Newton, KS
Williamson, George L.	**050**	Phoenix, AZ
Williamson, Harold A.	**026**	Columbia
Willis, Carol	**046**	Moberly
Willis, David	**222**	St. Louis
Willman, Charles R.	**030**	Springfield
Willman, Martin L.	**189**	St. Charles
Willman, Vallee L.	**190**	St. Louis
Wills, Theodore E.	**026**	Columbia
Willumsen, Henry C.	**030**	St. Joseph
Wilmas, John H.	**216**	St. Louis
Wilson, Bryan D.	**050**	Overland Park, KS
Wilson, David E.	**050**	Kansas City
Wilson, George P.	**026**	Columbia
Wilson, J. Mark	**082**	Springfield
***Wilson, James W.**	**082**	Springfield
Wilson, Roy E.	**082**	Springfield
Wilson, Timothy A.	**050**	Kansas City
Wilson, William R., Jr.	**026**	Columbia
Wilson, William T.	**125**	Independence
Wilt, David A.	**125**	Kansas City
Wimmer, Warren J.	**190**	Florissant
Windmiller, M. Eugene	**026**	Columbia
Winer, Herbert J.	**125**	Overland Park, KS
Winkelman, Gail L.	**218**	Columbia
Winkelmann, Mary K.	**126**	Shawnee Mission, KS
Winkelmeyer, William K.	**026**	Columbia
Winkler, Terry	**082**	Springfield
Winnacker, John L.	**026**	Columbia
Winship, Daniel H.	**002**	Maywood, IL
Winsky, Arlen D.	**082**	Springfield
Winter, Hillary B.	**216**	St. Louis
Winter, Tyrus D.	**190**	St. Louis
Winters, Chad A.	**226**	Cape Girardeau
Winton, Mark D.	**058**	Jefferson City
Wipfler, Earl J.	**189**	St. Charles
Wise, George W.	**125**	Shawnee Mission, KS
Wise, Morris F.	**125**	Kansas City
Wissner, Seth E.	**190**	St. Louis
Withrow, John B.	**050**	Kansas City
Witten, David M.	**026**	Columbia
Wittgen, Edward M.	**190**	St. Louis

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Wittmer, Marc R.	**082**	Springfield
Wolaniuk, Anna C.	**190**	St. Charles
Wolf, Jack W.	**125**	Kansas City
Wolfe, Edward M.	**190**	St. Louis
Wolfe, James B.	**082**	Springfield
Wolfe, John E.	**082**	Springfield
Wolff, Andrew B.	**222**	St. Louis
Wolff, Dolores P.	**190**	Chesterfield
Wolff, Gerald A.	**190**	Tuscon, AZ
Wolff, Harold D.	**190**	St. Louis
Wolski, James R.	**082**	Springfield
Woltjen, John A.	**125**	Blue Springs
Womack, Stephanie E.	**026**	Columbia
Won, Russell	**190**	St. Louis
Wonder, Donald	**208**	Branson
Wood, John A.	**190**	Chesterfield
Wood, Thomas O.	**034**	Poplar Bluff
Woodall, Charles E., III	**220**	Mission, KS
Woodberry, Kerri M.	**190**	St. Louis
Woodley, Michele C.	**190**	St. Louis
Woodruff, Lauren	**222**	St. Louis
***Woods, Brenda L.**	**058**	Hartsburg
Woodson, Mark E.	**190**	St. Louis
***Woodward, Owen L.**	**046**	Atlanta
Woodward, William W.	**125**	Holiday Island, AR
***Woody, Susan A.**	**126**	Kansas City
Wool, Gerald	**190**	St. Louis
Woolery, William G.	**178**	Sedalia
Woolsey, Joyce E.	**190**	St. Louis
Wooten, Michael B.	**082**	Springfield
Workman, George M.	**207**	Hermann
Worth, Eugene R.	**026**	Columbia
Wortmann, Robert F.	**125**	Hilton Head Island, SC
Wotawa, William J.	**190**	St. Louis
Wright, Andy J.	**082**	Springfield
Wright, Jason	**220**	Kansas City, KS
Wright, Jeffrey M.	**190**	St. Louis
***Wright, Michael D.**	**030**	St. Joseph
***Wright, Robert A.**	**190**	St. Louis
Wright, Robert W., III	**125**	Kansas City
Wright, William P.	**190**	St. Louis
Wu, Thomas Y.	**222**	St. Louis
Wu, William Q.	**125**	Prairie Village, KS
Wuebker, Maria-Valeri	**220**	Mission, KS
Wuellner, David H.	**178**	Sedalia
Wulfers, Michael C.	**042**	Cape Girardeau
Wunsch, Hannah	**222**	St. Louis
Wurm, Michael J.	**158**	Maryville
Wurr, Dieter H.	**190**	St. Louis
Wurster, Jerry B.	**125**	Prairie Village, KS
Wurster, Mark W.	**125**	Kansas City
Wurster, W. Joel	**125**	Parkville
Wurtz, Mary M.	**125**	Independence
Wyatt, Ursula	**218**	Columbia
Wyrsch, Bradley	**082**	Springfield
Wyrsch, Leo M.	**082**	Springfield

Y

Yahnke, David G.	**138**	Farmington
Yalavarthi, Kishan	**220**	Kansas City
Yang, H. Kell	**026**	Columbia
Yang, John S.	**174**	Ste. Genevieve
Yangco, Diego T., Jr.	**027**	Madison, FL
Yanover, Robert A.	**190**	St. Charles
Yarbro, John W.	**026**	Columbia
Yardeni, Dayna	**216**	St. Louis
Yasul, Jose I.	**216**	St. Louis
Yates, Charles L.	**026**	Columbia
Yates, Karen	**042**	Cape Girardeau
Yeast, John D.	**125**	Kansas City
Yedlin, Jay H.	**125**	Kansas City
Yeh, Peter	**222**	St. Louis
Yeh, Richard T.	**216**	St. Louis
Yeleti, Ramarao	**050**	N. Kansas City
Yeoh, Cindy	**222**	St. Louis
Yerra, Shanti S.	**082**	Springfield
Yingling, David G.	**042**	Cape Girardeau
***Yocum, Russell S.**	**125**	Platte City
Yoder, Amy M.	**220**	Kansas City, KS
Yoo, Jane	**222**	St. Louis
Yoon, Jin S.	**078**	Chillicothe
Yoon, Kong-Woo	**190**	St. Louis
Youmans, Ronald A.	**125**	Prairie Village, KS
Young, Desmond J.	**220**	Kansas City
Young, Kenneth R.	**082**	Springfield
***Young, Michael A.**	**058**	Jefferson City
Young, Patricia A.	**050**	Leawood, KS
Young, Paul H.	**190**	St. Louis
Young, Robert A.	**190**	Chesterfield
Young, Robert B.	**135**	Rolla
Young, Thomas W.	**125**	Kansas City
Yoxall, Kelly E.	**125**	Kansas City
Yu, Hwei-Ju A.	**218**	Columbia
Yu, Mario K.	**125**	Kansas City
Yu, Simon M.	**190**	St. Louis
Yuen, Benjamin H.	**042**	Cape Girardeau
Yuen, Carrie H.	**126**	Kansas City, KS
Yuen-McKinney, Melanie	**126**	Independence
Yusen, Roger D.	**195**	St. Louis

Z

Zacharias, Kulangara P.	**026**	Columbia
Zahn, Robert L.	**082**	Ozark
Zanol, John M.	**026**	Columbia
Zanol, Karen E.	**026**	Columbia
Zehnder, Kenneth W.	**190**	St. Louis
Zeigler, Joseph M.	**190**	St. Louis
Zekert, Horst	**190**	St. Louis
Zemany, Laura	**222**	St. Louis
Zerr, Charles H.	**125**	Independence
Zerrer, Jason D.	**218**	Columbia
Ziegler, Robert E.	**190**	St. Louis
Ziemianski, Matthew C.	**125**	Kansas City
Zimmerman, Herbert B.	**190**	St. Louis
Zitsch, Robert P., III	**026**	Columbia
Zivnuska, Frederick R.	**190**	St. Louis
Zoller, David D.	**125**	Blue Springs
Zuehlke, David A.	**102**	Joplin
Zujko, Richard D.	**135**	Rolla
Zukowski, Edward T.	**190**	Chesterfield
Zurowski, Susan M.	**026**	Columbia
Zylka, J. Michael	**190**	St. Louis

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*Doctor of Osteopathy

Primary Specialty Codes

AS	Abdominal Surgery
ADM	Addiction Medicine
ADP	Addiction Psychiatry
AMI	Adolescent Medicine (Internal Medicine)
ADL	Adolescent Medicine (Pediatrics)
OAR	Adult Reconstructive Orthopedics
AM	Aerospace Medicine
A	Allergy
AI	Allergy & Immunology
ALI	Clinical Laboratory Immunology (Allergy & Immunology)
PTH	Anatomic Clinical Pathology
ATP	Anatomic Pathology
AN	Anesthesiology
BBK	Blood Banking/Transfusion Medicine
ICE	Clinical Cardiac Electrophysiology
CTS	Cardiothoracic Surgery
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
PCH	Chemical Pathology
CHP	Child and Adolescent Psychiatry
CHN	Child Neurology
CBG	Clinical Biochemical Genetics
CCG	Clinical Cytogenetics
CG	Clinical Genetics
DDL	Clinical and Laboratory Dermatological Immunology
ILI	Clinical and Laboratory Immunology (Internal Medicine)
PLI	Clinical and Laboratory Immunology (Pediatrics)
CMG	Clinical Molecular Genetics
CN	Clinical Neurophysiology
CLP	Clinical Pathology
PA	Clinical Pharmacology
CRS	Colon & Rectal Surgery
CFS	Craniofacial Surgery
CCA	Critical Care Medicine (Anesthesiology)
CCM	Critical Care Medicine (Internal Medicine)
NCC	Critical Care Medicine (Neurological Surgery)
OCC	Critical Care Medicine (Obstetrics & Gynecology)
PCP	Cytopathology
D	Dermatology
DMP	Dermatopathology
DS	Dermatologic Surgery
DIA	Diabetes
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology, Diabetes and Metabolism
EP	Epidemiology
FPS	Facial Plastic Surgery
FP	Family Practice
FOP	Forensic Pathology
PFP	Forensic Psychiatry
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery
FPG	Geriatric Medicine (Family Practice)
IMG	Geriatric Medicine (Internal Medicine)
PYG	Geriatric Psychiatry
GYN	Gynecology
GO	Gynecological Oncology
HS	Hand Surgery
HNS	Head & Neck Surgery
HEM	Hematology (Internal Medicine)
HMP	Hematology (Pathology)
HO	Hematology/Oncology
HEP	Hepatology
IG	Immunology
PIP	Immunopathology
ID	Infectious Disease
IM	Internal Medicine
MPD	Internal Medicine/Pediatrics
LM	Legal Medicine
MFM	Maternal & Fetal Medicine
MXR	Maxillofacial Radiology
MFS	Maxillofacial Surgery
MG	Medical Genetics
MDM	Medical Management
MM	Medical Microbiology
ETX	Medical Toxicology (Emergency Medicine)
PDT	Medical Toxicology (Pediatrics)
PTX	Medical Toxicology (Preventive Medicine)
OMO	Musculoskeletal Oncology
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NRN	Neurology/Diagnostic Radiology/Neuroradiology
NS	Neurological Surgery
NP	Neuropathology
RNR	Neuroradiology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OSS	Orthopedic Surgery of the Spine
OTR	Orthopedic Trauma
OFA	Foot and Ankle, Orthopedics
OMM	Osteopathic Manipulative Medicine
OTO	Otolaryngology
OT	Otology/Neurotology
APM	Pain Management (Anesthesiology)
PMD	Pain Medicine
PLM	Palliative Medicine
PTH	Pathology
PDA	Pediatric Allergy
PAN	Pediatric Anesthesiology (Pediatrics)
PDC	Pediatric Cardiology
CCP	Pediatric Critical Care Medicine
PE	Pediatric Emergency Medicine
PEM	Pediatric Emergency Medicine (Pediatrics)
PDE	Pediatric Endocrinology
PG	Pediatric Gastroenterology
PHO	Pediatric Hematology/Oncology
PDI	Pediatric Infectious Disease
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
OP	Pediatric Orthopedics
PDO	Pediatric Otolaryngology
PP	Pediatric Pathology
PDP	Pediatric Pulmonology
PDR	Pediatric Radiology
PPR	Pediatric Rheumatology
NSP	Pediatric Surgery (Neurology)
PDS	Pediatric Surgery (Surgery)
UP	Pediatric Urology
PD	Pediatrics
PM	Physical Medicine & Rehabilitation
PS	Plastic Surgery
PRO	Proctology
P	Psychiatry
PYA	Psychoanalysis
MPH	Public Health and General Preventive Medicine
PCC	Pulmonary Critical Care Medicine
PUD	Pulmonary Disease
RO	Radiation Oncology
RP	Radiological Physics
R	Radiology
RIP	Radioisotopic Pathology
REN	Reproductive Endocrinology
RHU	Rheumatology
SP	Selective Pathology
SM	Sleep Medicine
SCI	Spinal Cord Injury
ESM	Sports Medicine (Emergency Medicine)
FSM	Sports Medicine (Family Practice)
ISM	Sports Medicine (Internal Medicine)
OSM	Sports Medicine (Orthopedic Surgery)
PSM	Sports Medicine (Pediatrics)
CCS	Surgical Critical Care (Surgery)
SO	Surgical Oncology
TR	Therapeutic Radiology
TS	Thoracic Surgery
TRS	Trauma Surgery
TTS	Transplant Surgery
UM	Underseas Medicine
U	Urology
VIR	Vascular and Interventional Radiology
VM	Vascular Medicine
VS	Vascular Surgery

In addition to the above, the following specialty designations are also used:

OS	Other (i.e., a specialty other than those appearing above)
US	Unspecified

Membership Roster by Primary Specialties

(Including name of city and code number of each member's component medical society.)

Allergy (A)

Berdy, Susan S. St. Louis	190
Bloomberg, Gordon R. Chesterfield	190
Caldwell, Joseph L. Springfield	082
Cooper, Barry J. St. Louis	190
Loren, Michael L. Independence	125
McMorrow, Nora K. Crestwood	190
Miles, Wayne B. Springfield	082
Nguyen, Helen T. St. Joseph	030
Payne, David E. Columbia	026
Stricker, William E. Rolla	135
Thiel, J. Allen St. Louis	190
Vandewalker, Mark L. Columbia	026
Wood, John A. Chesterfield	190
Wright, Jeffrey M. St. Louis	190

Allergy & Immunology (AI)

Berson, Douglas R. Chesterfield	190
Bolinske, Robert E. St. Louis	190
Critchlow, Michael E. Cape Girardeau	042
Dankner, Rand E. Chesterfield	190
Kanarek, Henry L. Kansas City	125
Korenblat, Phillip E. St. Louis	190
Landwehr, Lawrence P. Warrensburg	110
Lux, Gregory K. Springfield	082
Onder, Robert F. St. Louis	190
***Sacha, Robert F.** Cape Girardeau	042
Straub, David L. Joplin	102
Tuck, Janna M. Cape Girardeau	042

Anesthesiology (AN)

Abada, Rolando St. Louis	190
Adams, Riley R. Cape Girardeau	042
Almuttar, Wasif F. Maryville	158
Arnold, Donald E. Ballwin	190
Axness, Mark E. Springfield	082
Bagby, Jack M., Jr. Springfield	082
***Baker, Jay P.** Springfield	082
Bashyakarla, Rajeeva K. Joplin	102
Batan, Ruby L. Chesterfield	190
Baudendistel, Lawrence J. St. Louis	190
Behbahani, Parviz M. Bridgeton	190
Bell, Stephen St. Louis	190
Bernard, Lisa Kansas City	125
Blum, Carol A. Excelsior Springs	002
Bollier, Barbara G. Kansas City	002
Booth, Randall K. Nevada	214
Booton, Derek V. Kansas City	125
Bowenschulte, Bradley A. Springfield	082
Bowser, Robert L. Independence	050
Brazil, Maria J. Pacific	002
Brian, William J. Springfield	082
Brigden, Robert B. Neosho	102
Brown, Freeman F., III Ballwin	190
Brown, Norbert W. Kansas City	125
Buchele, Sheila Marie Joplin	102
Bucol, Kevin D. St. Louis	190
Bult, Mark J. Springfield	082
Butterfield, Mari Anne Lee's Summit	125
Casement, Brian A. Kansas City	125
Chang, Chil K. Columbia	026
Charapata, Steven G. Kansas City	125
Chien, David W. St. Louis	190
Chunduri, Krishna R. St. Louis	190
***Ciliberti, John A.** Kansas City	050
Cobb, Milton L. St. Louis	190
Cohen, Harry B. Columbia	014
Cole, Donald E. Columbia	066
Coleman, Kevin A. St. Louis	190
Cook, James R. Springfield	082
***Corzine, John J.** St. Joseph	030
Couper, Nicholas B. Columbia	026
Criscione, James S. St. Louis	190
Crumpacker, Rex K. Joplin	102
Cunningham, Milamari A. Columbia	026
Daily, James M. Springfield	082
***Daniels, William B.** Leawood, KS	125
Danner, Shavonne L. Kansas City	125
***Davis, Larry E.** N. Kansas City	050
***Delaney, Adrain J., Jr.** Kansas City	125
DeBoard, James W. St. Louis	190
DeCosta, Thomas St. Louis	190
***DeLucia, Joseph A.** Potosi	206
Doerhoff, Adelia L. Jefferson City	058
Dolan, Patrick H. St. Louis	190
Eggers, George W., Jr. Columbia	026
Ellis, S. Christopher Overland Park, KS	125
Esther, John W. Springfield	082
Faszholz, Mark S. Chesterfield	190
Fibuch, Eugene E. Kansas City	125
***Fisher, Robert B.** Columbia	026
Flores, Jhonson E. Chesterfield	190
Fogel, Steven T. Chesterfield	190
Foote, Daniel D. Springfield	082
Forand, Joseph M. St. Louis	190
Forstot, Robert M. St. Louis	190
***Frederick, Mark R.** Jefferson City	058
Friedman, Michael J. Columbia	026
Fromme, Glenn A. Springfield	082
Fryer, Dorothy S. St. Louis	190
Gholkar, Vijay R. Kansas City	125
Gibbons, James J. St. Louis	190
Gibbons, Robert T., Jr. Overland Park, KS	125
Gibson, William P. Chesterfield	190
Gilliland, Craig Kansas City	002
Ginsberg, Fred B. St. Louis	190
Glenski, James A. Kansas City	125
Graham, John D. St. Louis	190
Granberg, Steven J. St. Louis	190
Grubb, Michael M. Joplin	102
Guarino, Anthony H. Chesterfield	190
Gunderson, Jeffrey K. Springfield	082
Gupta, Nilakshi Columbia	026
Guy, Cynthia S. St. Louis	190
Hagen, Douglas W. Kansas City	125
Hahn, Steven L. St. Louis	002
Hari, Magaral S. Joplin	102
Hartmann, Michael L. Richmond Heights	002
Heise, Julie R. Kansas City	125

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*Doctor of Osteopathy

ANESTHESIOLOGY

Herold, Robert E.	St. Charles	189
Hervey, William H.	Kansas City	125
Hill, Michael L.	Joplin	102
Hoech, George P., Jr.	Kansas City	125
Holloway, Robert B.	St. Louis	190
Holtmann, Barbel	St. Louis	190
Horacek, Jeri L.	Springfield	082
Huff, Kalaichelvi R.	Joplin	102
*Hull, Jeffrey F.	Kansas City	125
Hull, Timothy A.	Kansas City	125
Iwane, Akira	Chesterfield	190
Janeczko, Gregory F.	Springfield	082
Jenkins, James J.	St. Louis	190
Johnson, Garry A.	St. Louis	190
Jones, Robin R.	Columbia	026
Jorgensen, Eric D.	Columbia	026
Joshi, Surekha K.	St. Louis	190
Keller, Barbara P.	Columbia	026
Kelly, James B.	Kansas City	125
Kenney, John D., III	Kansas City	125
*Kesseler, Randall G.	Mountain Grove	206
King, James A.	Des Peres	002
Kiyanclar, M. Emin	St. Louis	190
Knop, Kevin F.	Liberty	002
Kohm, Mary Jane F.	Ladue	002
Kraynack, Barry J.	St. Louis	002
Krug, Paul E.	Kansas City	125
Kulkarni, Nandini S.	St. Louis	190
Kussman, Mary E.	St. Louis	002
Lampert, Benjamin A.	Springfield	082
Landrum, Alice L.	Columbia	026
Lawson, Noel W.	Columbia	026
Lee, Leander K.	St. Louis	190
Lerner, Bruce	Independence	125
*Logston, David G.	Springfield	082
Lonergan, James H.	Kansas City	125
Luby, Maureen T.	St. Louis	190
*Lucio, John C.	Jefferson City	058
Ludwikosky, Mike A.	Lee's Summit	125
Lytle, Michael F.	Shawnee Mission, KS	125
Maddipati, Sreedevi	St. Louis	190
Matson, Jeffrey A.	Kansas City	125
Matthews, J. Mark	Kansas City	125
Mayuga, Edgardo G.	St. Louis	190
McCord, E. Scott	Columbia	026
McCray, Stephen A.	N. Kansas City	050
McDonald, Michael G.	Joplin	102
Mestad, Peter H.	Kansas City	125
Meyer, D. Joseph, Jr.	Columbia	026
*Michael, Roy A.	Jefferson City	058
Miller, Robert N.	St. Louis	190
Moore, Richard E.	Cape Girardeau	042
*Morley, Ronald F.	Jefferson City	058
Morrison, Robert R.	Kansas City	050
Muncy, Gary A.	Chesterfield	190
Nelson, Richard E.	Kansas City	125
*Neuenswander, Keith W.	Independence	050
Nevett, Robert E.	Washington	207
Nielsen, Carl H.	St. Louis	190
Nordhues, Craig A.	Springfield	082
Nye, Robert A.	St. Louis	190
Oakley, Margaret M.	St. Louis	190
Opper, Susan E.	Kansas City	125
Orr, Robert M.	N. Kansas City	050
Owens, William D.	St. Louis	190
Page, Sam L., Jr.	St. Louis	190
Parker, Craig A.	Kansas City	125
Parker, Kim E.	Kansas City	125
Pavelonis, Joel D.	Kansas City	002
Perryman, Kathy M.	Kansas City	125
Petersen, Larry D.	Springfield	082
Piontek, James F.	Liberty	050
Politi, Gregory B.	Kansas City	125
Porter, Michael J.	Kansas City	125
Porter, Susan S.	Kansas City	125
*Probst, James E., Jr.	Jefferson City	058
Pryor, Ira Joe	Joplin	102
Rao, Vijaya Kumar P.	Joplin	102
*Ray, Terry L.	Columbia	026
Reaney, John A.	Kansas City	002
Roa, Necita L.	St. Louis	002
Robertson, Terence A.	Leawood, KS	125
Romkema, George E.	St. Louis	190
Rumpf, Ronald P.	Columbia	026
*Russell, Robert B.	Cape Girardeau	042
Salathe, Gregg J.	Springfield	082
Schane, Catherine L.	Springfield	082
Schmidt, Stephen D.	St. Louis	002
Schneider, J. Michael	Springfield	082
Schnurr, Thomas C.	Jefferson City	058
Schuessler, Edward C.	St. Albans	190
Shelley, William C.	Blue Springs	002
Shimoda, Kumiko T.	Chesterfield	002
*Shipman, Wade M.	Rogersville	082
Smith, Sally L.	Chesterfield	190
Smith, Stephen R.	St. Louis	190
*Smith, Toni R.	Kirksville	148
*Steele, Brian K.	Joplin	102
Steer, Phyllis L.	Kansas City	002
Stewart, Angela R.	Columbia	026
Stoops, Stephen L.	Independence	125
Stuppy, Mary F.	Springfield	002
Subbaiah, Kosuri V.	Ballwin	190
*Suthoff, Jim	Joplin	102
*Tanner, Scott W.	Jefferson City	058
Tate, Kara L.	Kansas City	125
Tatini, Paparao	St. Louis	002
*Tewis, Huey D.	Cape Girardeau	042
Thomas, Elizabeth H.	Kansas City	125
Thomas, James J.	Kansas City	125
Thompson, David E.	Lee's Summit	125
Thornhill, Joseph M.	St. Louis	190
Tiojanco, Milagros E.	Kansas City	125
Tompson, Richard G.	West Plains	206
Vallurupalli, Vijayalakshmi	Bridgeton	190
Velander, Robert D.	Blue Springs	125
Venneman, Charles R.	Kansas City	125
*Vialle, Gene M.	Kansas City	125
Villafuerte, Nila A.	St. Louis	190
Walker, Randal E.	St. Louis	190
Waring, J. Michael	Kansas City	125
Watson, Timothy B.	Columbia	026
Weaver, Mark E.	Springfield	082
*Webb, James J.	Joplin	102
Wempe, Michael J.	St. Joseph	030
Westcott, Bruce R.	Cape Girardeau	042
Wilhite, Tria K.	Shelbyville	150
Wilkinson, Linda	Kansas City	125

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*Doctor of Osteopathy

Williams, C. Mark	125	Kansas City
Williams, Todd L.	102	Joplin
Wolff, Dolores P.	190	Chesterfield
Worth, Eugene R.	026	Columbia
***Wright, Michael D.**	030	St. Joseph
Wright, Robert W., III	125	Kansas City
Yates, Charles L.	026	Columbia
Yedlin, Jay H.	125	Kansas City
Young, Kenneth R.	082	Springfield
Young, Patricia A.	050	Leawood, KS

Anatomic Pathology (ATP)

Wang, Helena H.	058	Jefferson City

Blood Banking/ Transfusion Medicine (BBK)

Menitove, Jay E.	125	Kansas City

Critical Care Medicine (CCA) (Anesthesiology)

Saak, Thomas E.	002	St. Louis

Critical Care Medicine (CCM) (Internal Medicine)

Freeman, Brad	190	St. Louis
Gorman, Mary Jo	190	St. Louis

Cardiovascular Disease (CD)

Akin, C. David	125	Independence
Apprill, Phillip G.	190	St. Louis
Banerjee, Dilip	207	Washington
Barr, W. Kent	125	N. Kansas City
Bateman, Timothy M.	125	Kansas City
Biel, Stanley I.	190	Bridgeton
Biggs, F. Douglas	030	St. Joseph
Bloom, Stephen A.	125	Overland Park, KS
Bogart, Douglas B.	125	N. Kansas City
Bresnahan, Dennis R.	125	Kansas City
Brown, David L.	120	Osage Beach
Callicoat, Paul E., Jr.	102	Joplin
Chapman, James B.	042	Cape Girardeau
Chun, Duck Sung	190	St. Louis
Cochran, David S.	082	Springfield
Conn, Robert D.	125	Kansas City
Cooksey, Jon D.	190	St. Louis
Corcoran, Francis H.	102	Joplin
Cupp, Gerald V.	026	Columbia
Davis, J. Lawrence	190	Bridgeton
DeFelice, Charles E.	042	Cape Girardeau
Drozda, Joseph P., Jr.	190	Chesterfield
Dwyer, James G.	190	St. Louis
Fagan, Leonard F., Jr.	190	St. Louis
Farrar, Michael W.	125	Kansas City
Freeman, James A.	026	Columbia
Gafford, Franklin H., IV	190	St. Louis
George, Achenklinju K.	206	West Plains
Gibson, Paul H.	190	St. Louis
Godlewski, Kris J.	125	Kansas City
Good, Thomas H.	125	Kansas City
Ha, Richard J.	150	Hannibal
Hamilton, William P.	190	St. Louis
Hammond, Billy A.F.	042	Cape Girardeau
***Handlin, Larry R.**	014	Mexico
Harshman, David M.	190	St. Louis
Haycraft, Gordon L.	042	Cape Girardeau
Hegde, S. Roy	125	Kansas City
Henry, Clarke L., Jr.	125	Kansas City
Herman, Robert L.	125	Kansas City
Hills, Joe E.	082	Springfield
Hindupur, Mohan R.	030	St. Joseph
Huber, Kenneth C.	125	Kansas City
Hubert, John W.	190	Bridgeton
Jackson, Jay A.	125	Kansas City
Jain, Savitri G.	190	St. Louis
Johnson, Warren L., Jr.	125	Kansas City
Kennett, Jerry D.	026	Columbia
Kindred, Lynn H.	125	Kansas City
Kistler, W. David, Jr.	190	St. Louis
LaFoe, William K.	042	Cape Girardeau
Lee, Gerald B.	214	Kansas City
Lee, Jung H.	106	Crystal City
Lipoff, Jay I.	042	Cape Girardeau
Long, John W.	026	Columbia
McCallister, Ben D.	125	Kansas City
Meyer, Randall E.	058	Jefferson City
Miller, John T.	125	N. Kansas City
Mizell, Myron W.	082	Springfield
Montgomery, Michael A.	125	N. Kansas City
Moore, Thomas B.	102	Joplin
Morello, Patrick J.	058	Jefferson City
Oliver, G. Charles	002	St. Louis
Penilla, Antonio R.	190	St. Louis
Politte, Lenard L.	026	Columbia
Porter, Charles B.	125	Kansas City
Retter, Kenneth W.	042	Cape Girardeau
Riner, Ronald N.	190	St. Louis
Roselman, Michael J.	082	Springfield
Rutherford, Barry D.	002	Kansas City
Ruwitch, Joseph F., Jr.	190	St. Louis
Sanders, Jack S.	058	Jefferson City
Scharf, Daniel	125	Overland Park, KS
Selke, Kenneth G.	190	Chesterfield
Skolnick, David G.	125	Kansas City
Spadaro, James J.	190	St. Louis
Spitler, Allen L.	042	Cape Girardeau
Spurny, Otto M.	125	Kansas City
Stahl, Lloyd D.	125	Overland Park, KS
Steinhaus, David M.	125	Kansas City
Stickley, Louis P.	190	St. Louis
Stinnett, D. Mitchell	102	Joplin
Stuppy, Robert J.	102	Joplin
Talbert, Clifford R.	042	Cape Girardeau
Valuck, Richard P., Jr.	150	Hannibal
Whiting, Richard B.	190	St. Louis
Wolff, Gerald A.	190	Tuscon, AZ
Zuehlke, David A.	102	Joplin

Cardiovascular Surgery (CDS)

Bailey, Colin E.	026	Columbia
Borkon, A. Michael	125	Kansas City
Bourland, Mary E.	102	Joplin
Bryant, Lester R.	026	Asheville, NC
Crouch, John A.	026	Columbia
Curtis, Jack J.	026	Columbia
Daniel, William C.	125	Kansas City
Demmy, Todd L.	026	Columbia
Hannah, Hamner, III	125	Kansas City
Jung, Simon C.	050	N. Kansas City

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Kase, James B., Jr.	125	N. Kansas City
Kramer, Jeffrey B.	125	Kansas City
Lammoglia, Francisco J.	030	St. Joseph
Laster, Steven B.	125	Kansas City
Lawhorn, Stephanie L.	125	Shawnee Mission, KS
Liston, Michael J.	050	N. Kansas City
Magalski, Anthony	125	Kansas City
Main, Michael L.	125	Kansas City
McCroskey, Brian L.	125	Kansas City
Meurer, Michael F.	082	Springfield
Ogle, William R.M.	042	Cape Girardeau
Rigden, L. Brick	125	N. Kansas City
Rogers, James D.	082	Springfield
Ruff, Paul G.	082	Springfield
Schmaltz, Richard A.	026	Columbia
Schneider, Alan M.	125	Overland Park, KS
See, W. Mike	026	Columbia
Stamatis, John J.	082	Springfield
Starr, Steven K.	125	N. Kansas City
Voelker, Donald J.	026	Columbia
Walls, Joseph T.	026	Columbia
Yeleti, Ramarao	050	N. Kansas City

Child Neurology (CHN)

Dodge, Philip R.	190	St. Louis
Prensky, Arthur L.	190	St. Louis

Child and Adolescent Psychiatry (CHP)

Daniel, A. E.	026	Columbia
Edwards, James E.	190	St. Louis
Inniss, Rosalyn E.	125	Kansas City
Lorenzo, Edilberto B.	125	Poplar Bluff
Poonawala, Huseni E.	125	Kansas City
Quiason, Emmeline P.	125	Independence
Shearer, Robert D.	058	Jefferson City

Clinical Pathology (CLP)

Bell, Gordon A.	125	Lee's Summit
Druet, Robert L.	082	Springfield
Godfrey, Stephen E.	190	St. Louis
Haake, Gregory K.	082	Springfield
Nomura, Roy M.	190	St. Louis
Raborar, Arteso C.	082	Springfield
Thal, Sanford M.	190	St. Louis

Colon and Rectal Surgery (CRS)

Brabbee, Gregory W.	190	St. Louis
Cirocco, William C.	125	Shawnee Mission, KS
Fleshman, James W.	190	St. Louis
Graham, Bruce D.	002	Shawnee Mission, KS
Kodner, Ira J.	190	St. Louis
Robbins, Philip L.	190	St. Louis
Schuval, David	190	St. Louis

Cardiothoracic Surgery (CTS)

Leidenfrost, Ronald D.	190	Chesterfield

Dermatology (D)

Ailor, Susan K.	026	Columbia
Albert, I. Renee	190	St. Louis
Anderson, Frank K.	189	St. Charles
Anderson, Philip C.	026	Columbia
Aronberg, Jerome M.	190	St. Louis
Ashby, Jennifer D.	125	N. Kansas City
Bauschard, Frederick D.	190	St. Louis
Dempsey, Kenneth J.	202	Sikeston
Dilworth, Jacquelyn B.	190	St. Louis
Dyer, Gary A.	030	St. Joseph
Forsman, Karen E.	190	St. Louis
Gentry, Michael A.	082	Springfield
Glaser, Dee Anna	002	St. Louis
Griffin, Darrell L.	138	Farmington
Gunn, Victoria	058	Jefferson City
Gunnoe, Robert E.	125	Kansas City
Hall, John C.	125	Kansas City
Hironimus, John E.	190	St. Louis
Hruza, George J.	190	St. Louis
Hruza, Luciann L.	002	Ladue
Kunin, Audrey Gottlieb	002	Kansas City
Lane, Daniel K.	190	St. Louis
Lynch, Thomas W.	082	Springfield
Major, Troy E.	082	Springfield
Marrs, David B.	189	St. Charles
Matlock, Mark S.	102	Joplin
McCadden, Michael E.	190	St. Louis
McEwen, Gary W.	125	N. Kansas City
Medler, P. Louis	190	St. Louis
Meidl, Susan M.	150	Hannibal
Melia, B.J., Jr.	125	Kansas City
Miller, Charles W.	190	St. Louis
Morrow, N. Eugene	082	Springfield
Oleson, Gale B.	125	Blue Springs
Palmer, Stephen M.	190	St. Louis
Perry, Lindell A.	014	Mexico
Portnoff, Lee S.	190	St. Louis
Powell, John A.	190	St. Louis
Reed, Jeffrey T.	190	St. Louis
Reese, Lester T.	190	St. Louis
Roller, James A.	026	Columbia
***Schwarze, Robert F.**	190	Florissant
Scott, Jamie A.	082	Springfield
Sengelmann, Roberta D.	190	St. Louis
Simmons, Jess S.	102	Joplin
Stoecker, William V.	135	Rolla
Swinfard, Ronald W.	026	Columbia
Thomas, F. Anthony	050	Kansas City
Tiefenbrunn, Sharon F.	190	St. Louis
Towery, Derek S.	102	Joplin
Tucker, Dolores R.	190	Chesterfield
Uhlemann, John H.	189	St. Charles
Vitale, Stephen J.	190	Chesterfield
Walsh, Richard J.	030	St. Joseph
Ward, Dana S.	026	Columbia
Werth, Joseph A.	058	Jefferson City
Wolfe, Edward M.	190	St. Louis
Zanol, Karen E.	026	Columbia
Ziegler, Robert E.	190	St. Louis
Zurowski, Susan M.	026	Columbia

Diagnostic Radiology (DR)

Amini, Jafar	002	Shawnee Mission, KS
Applewhite, Thomas A.	190	St. Louis
Baker, Karen S.	082	Springfield
Barton, Premsri T.	190	St. Louis
Beal, Catherine E.	190	St. Louis
Belshe, Sidney B.	058	Jefferson City
Boodram, Mitra B.	190	Maryland Heights

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Brent, Lanny R.	Springfield	**082**
Bridges, Jack L.	St. Joseph	**030**
Carlton, Lynn N.	Springfield	**082**
Churchill, Robert J.	Columbia	**026**
Cooper, Barry R.	N. Kansas City	**050**
Cram, John W.	Branson	**208**
Crawley, Jennifer H.	Kansas City	**125**
Crepps, Louis F.	St. Louis	**190**
Cronemeyer, Richard L.	Lee's Summit	**125**
Cusumano, Joseph V.	St. Louis	**190**
Cyriac, George K.	Mexico	**014**
Davis, Gene L.	Chesterfield	**190**
Day, Geoffrey A.	Joplin	**102**
Dell, Robert V.	Hannibal	**150**
Dierberg, Dale F.	Chesterfield	**207**
Engels, John T.	St. Louis	**190**
Ernst, Edwin C., III	St. Louis	**190**
Evens, Ronald G.	St. Louis	**190**
Fisher, James K.	Kansas City	**125**
Fletcher, Dale M.	St. Louis	**190**
Foss, Jonathan M.	St. Louis	**190**
Francis, Roger A.	Linn Creek	**120**
Gafarian, Kathleen	Springfield	**082**
Garvin, Charles F.	St. Louis	**190**
Geisse, Guillermo C.	St. Louis	**190**
Gennaoui, Jad M.	St. Louis	**190**
Glazer, Harvey S.	St. Louis	**190**
Goodhope, Karen F.	St. Louis	**190**
Graviss, E. Richard	St. Louis	**190**
Greditzer, Harry G., III	St. Louis	**190**
Gresick, Robert J., Jr.	St. Louis	**190**
Grunz, Donald J.	Creve Coeur	**190**
Hardy, Jeffery A.	St. Louis	**190**
Hazuka, David F.	Shawnee Mission, KS	**125**
Hillard, Alan E.	Columbia	**026**
Hoffman, Mark J.	St. Louis	**190**
Holloman, Walter G.	Ballwin	**190**
Howshar, Mark E.	Cape Girardeau	**042**
Idstrom, Mark E.	Kansas City	**125**
Jones, Maynard C., Jr.	Lee's Summit	**125**
Jones, Paul S.	Joplin	**102**
Junker, James A.	St. Louis	**106**
Keller, Stephen M.	St. Louis	**190**
Kopperman, Mordecai	Kansas City	**125**
Krahn, Michael J.	Kansas City	**050**
Lee, H.T.	Columbia	**026**
Levitt, Robert G.	St. Louis	**190**
Martin, David S.	Chesterfield	**190**
Mayes, Ben R.	St. Louis	**190**
McManus, Gerald	N. Kansas City	**050**
Moore, Michael T.	Nevada	**214**
O'Toole, Patrick M.	Kansas City	**125**
Oberle, Paul A.	Ballwin	**190**
Omell, Gary H.	St. Louis	**190**
Pohl, David L.	St. Louis	**190**
Pottenger, L. Kenneth	Joplin	**102**
Price, Hilton I.	St. Louis	**190**
Reuter, Gregory C.	Mission, KS	**125**
Rosenthal, Debra D.	St. Louis	**190**
Sadhu, Vijay K.	Columbia	**026**
Sallee, Skip	Ladue	**190**
Scearce, Robert L.	Jefferson City	**058**
Scheible, Robert F.	St. Louis	**190**
Schwegler, Robert G.	Shawnee Mission, KS	**125**
Shaplin, Alfred D.	Ballwin	**106**
Smith, Emily L.	St. Louis	**190**
Sobky, George H.	St. Charles	**190**
Soha, Joseph J., Jr.	Columbia	**026**
Stevens, Edward M.	St. Joseph	**030**
Stoecker, Willeford J.	Cape Girardeau	**042**
Sullivan, Dan T.	Springfield	**082**
Swaney, Charles M.	Columbia	**026**
Sweeney, Thomas P.	Republic	**082**
Szoko, Edward	St. Louis	**190**
Thalblum, Harvey	Kansas City	**125**
Thomasson, Jeffrey L.	St. Louis	**190**
Tobler, Jerry	Ballwin	**190**
Totty, William G.	St. Louis	**190**
Trotta, Philip C.	St. Louis	**190**
Vas, Wenzel G.	St. Louis	**190**
Weis, Ronald R.	Leawood, KS	**125**
Wiele, Kimberly N.	St. Louis	**190**
Wilcox, Dennis M.	Leawood, KS	**125**
Wilson, J. Mark	Springfield	**082**
Wolski, James R.	Springfield	**082**

Emergency Medicine (EM)

Adkins, Charlene	Columbia	**026**
Ammala, Edward D.	Rolla	**135**
Bell, Malinda H.	Shawnee Mission, KS	**125**
Berry, Danny T.	Cape Girardeau	**042**
Bonney, Samuel C.	Washington	**207**
Clark, Alan D.	Springfield	**002**
Collins, Samuel B.	Wrightsville Beach, NC	**026**
Criscione, James R., Jr.	St. Louis	**190**
DeCoursey, Kenneth A.	Cape Girardeau	**042**
***Draper, Richard E.**	Cape Girardeau	**042**
DuMontier, Alan J.	Chesterfield	**190**
Grandstaff, P. Matthew	Prairie Village, KS	**125**
Grisham, Thomas D.	Washington	**207**
Hicks, Robb R., IV	Cape Girardeau	**042**
Hierholzer, Rebecca S.	N. Kansas City	**125**
Judge, Steven J.	Washington	**207**
***Karr, Jerry L.**	Cape Girardeau	**042**
Keesal, Dennis	Chesterfield	**189**
Kensel, Scott	Springfield	**082**
Kolda, Michael A.	Cape Girardeau	**042**
***Kowalski, Mark**	Cape Girardeau	**042**
Labayen, Ricardo A.	Overland Park, KS	**125**
***Landers, Gary A.**	N. Kansas City	**050**
Lewis, Lawrence M.	St. Louis	**190**
Lombardo, Richard J.	Belton	**125**
Mazurek, Julie M.	N. Kansas City	**125**
McIntosh, Douglas A.	Cape Girardeau	**042**
McMurry, Ted A.	Springfield	**082**
Mecker, Robert	Washington	**207**
Meece, David R.	Cape Girardeau	**042**
Miller, Denise M.	Leawood, KS	**125**
Mire, Louis E.	Branson	**208**
Mobley, Gilbert L.	Springfield	**082**
Morgan, Edward B.	St. Louis	**190**
Nelson, Michael J.	Lee's Summit	**125**
Orr, Steven M.	Parkville	**125**
Pancoast, Charles H.	Cape Girardeau	**042**
Parks, William C.	Columbia	**026**
Poggemeier, David A.	St. Charles	**189**
Prickett, David C., Jr.	Kearney	**050**
Radakovich, Rick R.	Kansas City	**050**

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*Ramsey, Jesse R. Cape Girardeau	042
Randolph, Gary Joplin	102
Ratcliff, Keith M. Washington	207
Ricci, Walter J. Overland Park, KS	125
Riscoe, James M. Joplin	102
Robinson, Ronald L. Cape Girardeau	042
Russell, Steven L. Kansas City	050
*Schnur, David Cape Girardeau	042
Scott, Benn L. Cape Girardeau	042
Spurgeon, Stephen Maryland Heights	190
Steele, Mark T. Kansas City	002
Stoliar, John B. St. Louis	190
Sullivan, Christine Overland Park, KS	125
Svancarek, William P. St. Louis	190
Szewczyk, Michael J. Columbia	026
Toy, Karen L. Sedalia	178
Turner, Lanny M. St. Louis	190
*Turner, Timothy T. Barrington, IL	002
*Umfleet, Jeffrey C. Cape Girardeau	042
Waeckerle, Joseph F. Leawood, KS	125
Weber-Bornstein, Nancy Cape Girardeau	042
Wilson, Bryan D. Overland Park, KS	050

Endocrinology (END)

Duda, Ralph J., Jr. Springfield	082
Hellman, Richard N. Kansas City	125
Henson, Bruce E. Kansas City	125
James, Ronald C. Columbia	026
Koppers, Lawrence E. Liberty	050
Porte, Karen L. Joplin	102
Rosen, Howard M. N. Kansas City	125

Facial Plastic Surgery (FPS)

Buchwach, Kenneth A. Independence	125
deLeeuw, Karel A. Springfield	082
Ehlert, Tamara K. St. Louis	190
LaFerriere, Keith A. Springfield	082
Prstojevich, Steven J. Kansas City	125
Tanner, John P. Kansas City	125
Thomas, J. Regan St. Louis	190

Family Practice (FP)

Ahnemann, Janet L. Clinton	086
Allan, James E. Jefferson City	058
Allcorn, Donald K. Lincoln	178
Anglo, Luis B. St. Louis	190
*Asher, Kennett D. Jackson	042
Askew, John H. Sikeston	202
Auner, J. David Ironton	138
Bain, Kelly J. New Haven	207
Baker, Donald L. Union	207
Barbe, David O. Mountain Grove	206
*Bean, David K. Florissant	190
Belden, Jeffery L. Columbia	026
Bellamy, Bruce G. Clinton	086
Berner, Carol T. Springfield	082
*Bieser, R. Dan Cape Girardeau	042
Binz, Donald E. St. Peters	189
Boatright, Kevin Farmington	138
Bowles, Richard P. Liberty	050
Brockhaus, Jayne R. Warrensburg	110
Brown, Merlin D. St. Joseph	030
Brunworth, David Washington	207
Buffaloe, Robert N. Jefferson City	058
Buie, Steven E. Kansas City	125
*Bynum, Robert L. Columbia	026
Cady, Roger K. Springfield	082
Campbell, Albert J. Sedalia	178
Campbell, David C. St. Louis	190
Carey, Larry J. Springfield	082
Carney, Stephen E. Sikeston	202
Carranza, Mauro J. St. Louis	190
Carter, James E., Jr. Leawood, KS	125
Caster, Philip W. Lebanon	115
Cathcart, David L. Camdenton	120
Catron, David O. Cape Girardeau	042
Chaffin, Jerald D. Branson	208
*Chandra, Ram Higginsville	118
Chavez, Salvador St. Louis	190
Collison, R. Michael Strafford	082
Colwill, Jack M. Columbia	026
Comfort, George D. Mexico	014
Cravens, David D. Columbia	026
Cravens, William P. Fulton	038
Crosnoe, Janna R. Cape Girardeau	042
*Crow, Sam A., II Springfield	082
D'Angelo, James A. Blue Springs	125
Dang, Robert C. Pleasant Hill	214
Davis, Carl S. Lee's Summit	125
Davis, Thomas E. New Haven	207
Dean, Walter E. Maryville	158
*Depew, Deborah A. Cedar Hill	207
Derrington, Kenneth L. Laurie	120
DeLine, Jim Macon	046
Dierker, Harry D. Columbia	026
Dimayuga, Nestor G. Mansfield	206
Dixon, Druery J. West Plains	206
Dodson, Jack M. Jefferson City	058
Domke, Henry F. Jefferson City	058
Dorsch, Stephen E. Independence	125
Douglas, Steven L., II East Prairie	202
Downey, Jon P. Cape Girardeau	042
Dyer, Curtis W. Warrensburg	110
Ekern, H. Peter Mexico	014
Elcock, Devera M. St. Louis	190
*Eldenburg, Steven C. Sedalia	178
Elfrink, Melanie Eden Marshall	198
Elliott, Wendell H. Poplar Bluff	034
Engelking, David F. Jefferson City	058
Evans, Jeffry T. Hannibal	150
Franey, Michelle R. Kansas City	125
Freeland, Arthur G. Warrensburg	110
Gailey, Raymond K. Joplin	102
Galbraith, Polly M. Kansas City	125
George, Robert W. Cape Girardeau	042
Gilbirds, William M., II Kansas City	050
Glover, David Warrensburg	110
Goff, John E. Joplin	102
Good, Michael W. Springfield	082
Grable, James D. Cape Girardeau	042
Greenlund, Nelson C. Nevada	214
Griffin, Shawn St. Joseph	030
Griffith, S Kent Cape Girardeau	042
Groce, George D. Fulton	038
Hale, Arthur E., Jr. Forsyth	208
Hall, Terry E. Bethany	078
Halverson, Larry W. Springfield	082

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Hamid, Rashid S. Marshall	**198**
Hardy, Stanton L. Desloge	**138**
Harr, Patrick B. Maryville	**158**
Harris, Louis B. Bolivar	**066**
Haulard, Marcel E. Wright City	**190**
Hayden, Melvin R. Camdenton	**120**
Hayes, Nancy J. Mountain Grove	**206**
Herrmann, Deborah A. Marshall	**198**
Heutel, Lee B. St. Louis	**190**
Hite, Dennis E. Lebanon	**115**
Hoffmann, Alan L. Kansas City	**125**
Holzem, Craig S. Washington	**207**
Hopkins, Thomas A. Springfield	**082**
Hrabik, Brent Tarkio	**158**
Hubbard, Sally L. Springfield	**082**
Huffman, Larry Branson W.	**208**
Hunter, James K., Jr. Fairfax	**158**
Icaza, Ramiro Jackson	**042**
Jackson, Max G. Kansas City	**125**
Jenkins, Edward R. Laquey	**135**
Johnson, Lent C. Hannibal	**150**
Johnson, Patrick E. Farmington	**138**
Jones, Gordon Sikeston	**202**
Jones, Justin E. Mexico	**014**
Kairuz, Bartolome C. St. Louis	**190**
Kanne, Marty A. Kansas City	**050**
Kapp, Dave Perryville	**174**
Kasten, Mark C. Cape Girardeau	**042**
Kelley, Rebecca B. Auxvasse	**038**
Kenney, Douglas R. Clinton	**086**
***Kessler, Alan Z.** Kansas City	**125**
Kessler, William D., Jr. Joplin	**102**
Kim, Hee-Sun Springfield	**082**
Kimlinger, William R. Jefferson City	**058**
Klein, Kendel L. Mt. Vernon	**166**
Koon, Ben H. Bolivar	**066**
Kraemer, Edwin T. Lee's Summit	**125**
Kroutil, Candise D. Aurora	**166**
Kruse, Carl R. Palmyra	**150**
Laiben, Gregg R. Kansas City	**002**
Lauber, Joseph J. St. Louis	**190**
Lavery, Daniel P. Westphalia	**058**
***Law, Byron D.** Kansas City	**050**
***Leahy, Cindy** Jefferson City	**058**
Lee, Susan L. Kansas City	**125**
Legler, Larry E. Independence	**125**
Lepinski, Sandra L. Kansas City	**125**
Leroux, Gene H. Doniphan	**034**
Lischwe, Daniel H. Bridgeton	**190**
Long, Timothy P. Marthasville	**207**
Lueckenhoff, Rebecca R. Jefferson City	**058**
Luerding, Jeffrey A. Kansas City	**050**
Lukavsky, James P. Branson	**208**
Lutkewitte, Joseph F. Ste. Genevieve	**174**
Luzania, Randy C. Overland Park, KS	**125**
Lyle, Robt R. Versailles	**120**
Mahaffey, Brian L. Springfield	**082**
Markway, Gregory A. Independence	**125**
Marshall, William G. Glasgow	**026**
Martin, Mark W. Lee's Summit	**125**
Martin, Robert A. West Plains	**206**
Maska, Monte D. Springfield	**082**
Mason, Mary Jane Steelville	**135**
Masters, Edwin J. Cape Girardeau	**042**
McDowell, James W. Macon	**046**
McFarland, Rodney J. Neosho	**166**
Mehaffy, Orville A. Joplin	**102**
Mehr, David R. Columbia	**026**
***Melchior, David E.** Perryville	**174**
Memken, John A. Hannibal	**150**
Messmore-Arn, V. Paula Kansas City	**125**
Meyer, Jerry L. Concordia	**118**
Miller, William D. St. Joseph	**030**
Molberg, Peter J. Springfield	**082**
Montes, Arturo C. Florissant	**190**
Morgan, W. Tom , Jr. Columbia	**026**
Morton, Wayne L. Osceola	**214**
Mueller, Randall E. Columbia	**026**
Munger, Michael L. Kansas City	**125**
Myers, Carl M. Platte City	**125**
Nadolski, Gary S. St. Joseph	**030**
Newman-Koehn, Mica K. Marshall	**198**
Noel, Alan DeMesa Steelville	**135**
North, Michael S. Springfield	**082**
O'Donnell, Gregory P. Overland Park, KS	**125**
Offner, Jennifer K. Palmyra	**150**
Ojascastro, Alejandro C. St. Louis	**190**
Oliver, Malcom B. Republic	**002**
Ostergaard, Daniel J. Kansas City	**125**
Ouellette, David F. Hannibal	**150**
Palen, James E. Cape Girardeau	**042**
Papreck, K. T. Marshall	**198**
Paris, William H. Bridgeton	**190**
Paterson, Jennifer L. Washington	**002**
Patterson, Donald R. Joplin	**102**
***Pewitt, Charles S.** Jackson	**042**
Philgreen, Donald E. Kansas City	**125**
Phillips, Kenneth D. Cape Girardeau	**042**
Phillips, Ronald L. Kirksville	**148**
Pinkham, Chris M. Kansas City	**050**
***Pioli, Lisa L.** Overland Park, KS	**125**
Pitney, Phillip W. Louisiana	**150**
Pon, Marcelino St. Louis	**190**
Porvaznik, Michael E. St. Louis	**190**
Potts, Donald A. Kansas City	**125**
Price, Richard C. Harrisonville	**214**
Prince, Yvonne M. Salem	**135**
Randolph, Bernard C. St. Louis	**190**
Reed, Leea Springfield	**082**
Reeder, Charles C. Smithville	**050**
Regas, Stephen L. Kansas City	**125**
Revels, Stephanie M. Fairway, KS	**125**
Reynolds, Susan K. St. Louis	**190**
Richardson, George A. Union	**207**
Robbins, Thomas D. Jefferson City	**058**
Robertson, William D. Poplar Bluff	**034**
Rogers, H. Bryan St. Louis	**190**
***Rosales, Mark A.** Linn	**058**
Royce, Debra L. Sarcoxie	**102**
Rues, Lawrence A. Kansas City	**125**
Ryan, David Trenton	**078**
***Sands, Michael E.** Jefferson City	**058**
Scharrer, Alan J. Holden	**110**
Schmitz, Ralph A. Monett	**166**
Schoentag, Diane J. Mexico	**014**
Scott, Kenneth F. Clinton	**086**
Scroggins, Larry Columbia	**026**
Shaw, James T. Hermann	**207**

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Shaw, Robert D.	Willow Springs	206
Shields, Lawrence S.	Springfield	082
Shinn, Michael E.	Kansas City	050
Siemer, Deanna M.	Jackson	042
***Sill, William**	St. Peters	189
Silvers, L. Michael	Kansas City	125
Sincox, Charles H.	Washington	207
***Slavek, Thanh H.**	West Plains	206
Smith, Claude F.	Willow Springs	206
Smith, Gilbert D.	Poplar Bluff	034
Sparkman, Thomas C.	Cape Girardeau	042
Spence, Paul A.	Cape Girardeau	042
Spurlock, Luther D.	Rolla	135
Spurney, Joe E.	Kansas City	125
Stanley, John O.	Kansas City	050
Stanton, Liza S.	O'Fallon	002
Steele, Jack T.	Bridgeton	190
Steenbergen, Michael	Jefferson City	058
Steiner, Marvin P.	Independence	125
Stringer, Kenton L.	Aurora	166
Stuerman, Lawrence G.	Louisiana	150
Suarez, Alberto	Lee's Summit	125
Tarvin, Randy J.	Lee's Summit	125
***Tarwater, James K.**	Kansas City	050
Tedrow, Jeffrey R.	Bolivar	066
Tegtmeyer, Chris	Lebanon	115
***Terpstra, Gregory K.**	Potosi	138
Thies, Jerome H.	Osceola	214
Thomas, Deborah G.	Cape Girardeau	042
Thompson, James E.	West Plains	206
***Thornton, Russell J.**	Higginsville	118
Tiemann, James H.	Lee's Summit	002
Till, Bennie N.	Poplar Bluff	034
Tobin, Marla J.	Warrensburg	110
Turner, James D.	Washington	207
Turner, Kirby L.	Poplar Bluff	034
Uketui, Ozoemenam I.	St. Joseph	030
Ulbrich, Jamie G.	Marshall	198
Van Zanten, Niko A.	Osceola	214
Vargas, Teodoro C.	Pacific	190
Villahermosa, Juanito L.	Savannah	010
Voszler, Richard B.	Cape Girardeau	042
***Walton, Frank C.**	Winona	206
Ward, Mark R.	Springfield	082
Wardell, M. Annette	Springfield	082
Warren, Ronda Lynn	Kansas City, KS	125
Warwick, Marion C.	Jefferson City	058
Watts, Samuel M.	Mt. Vernon	166
Weiss, James J.	Jefferson City	058
***Wescott, Thomas P.**	Holden	110
Wheeler, Robert L.	Harrisonville	214
Wilkins, Thomas L.	Kansas City	050
Williams, Paul A.	Kansas City	125
Williams, Rick W.	Ozark	082
Williamson, Harold A.	Columbia	026
Wilson, David E.	Kansas City	050
Wilson, Timothy A.	Kansas City	050
***Woodward, Owen L.**	Atlanta	046
Workman, George M.	Hermann	207
Wulfers, Michael C.	Cape Girardeau	042
Wurm, Michael J.	Maryville	158
Wurr, Dieter H.	St. Louis	190
***Yocum, Russell S.**	Platte City	125
Zanol, John M.	Columbia	026

Gastroenterology (GE)

Allen, Mark J.	Kansas City	125
Barber, Gregory	Kansas City	125
Brock, Arthur L.	Independence	125
Clement, Donald J.	Kansas City	125
Coleman, Terrence W.	Liberty	125
Cooper, Gary D.	Liberty	050
Cort, David H.	St. Louis	190
Culver, Perry J., Jr.	Kansas City	125
Cusworth, Robert	St. Charles	189
***Deffenbaugh, Larry D.**	Joplin	102
Elias, Ivan J.	Kansas City	125
Fedotin, Michael S.	Kansas City	125
Frederickson, Neil W.	St. Louis	190
Freilich, Brad	Overland Park, KS	125
Ginsberg, B. William	Kansas City	125
Gordon, Glenn L.	Mexico	014
Gurian, Lawrence E.	Springfield	082
Helzberg, John H.	Kansas City	125
Honaas, Trygve O.	Cape Girardeau	042
Hover, Alexander R.	Springfield	082
Jennett, Richard B.	Jefferson City	058
Kaster, Steven D.	Kansas City	002
Kouo, Louis	Cape Girardeau	042
Landers, Burnell	Independence	125
Lee, Wilfred	Cape Girardeau	042
Libel, Roy D.	Springfield	082
Marshall, Jay P., II	Chesterfield	190
McCullough, Joseph E.	Kansas City	125
McPhee, Mark S.	Kansas City	125
Mentgen, Carl N.	Springfield	082
Merritt, Gregory A.	Kansas City	125
Pelican, George	St. Louis	190
Petersen, James H.	Chesterfield	002
Sharp, John R.	Shawnee Mission, KS	125
Shuler, Frederick N.	Kansas City	125
Stein, Bernard	Joplin	102
Taormina, Marc K.	Independence	125
Walden, David T.	St. Louis	002
Woltjen, John A.	Blue Springs	125
Wooten, Michael B.	Springfield	082

General Practice (GP)

Allan, James R.	Shelbina	150
Armstrong, Elizabeth M.	Centralia	026
***Bader, Larry W.**	Columbia	026
Baldwin, Theodore R.	Excelsior Springs	118
Blaine, James R.	Springfield	082
Bridges, J. Rachelle	Forsyth	208
Bridges, Leonard W.	Forsyth	208
Burkhart, Susan M.	California	058
Campbell, James E.	Macon	046
Carleton, Charles E.	Farmington	138
Carpenter, Wallace	Rock Port	158
Conant, James F.	St. Joseph	030
Delcau, Carey M.	Ellisville	190
Dettmer, Robert F.	Ironton	138
Dudik, Randall G.	Rolla	135
Eldenburg, Donald O.	Sedalia	178
Frein, Donald E.	Harrisonville	214
***Gayle, David R.**	Piedmont	034
***Gayle, Richard E.**	Piedmont	034
Gunn, Jack	Versailles	120
Haynie, William W.	Butler	214

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Heath, Jimmy D. East Prairie	202
Hettinger, Brenda A. Camdenton	120
Holowaty, J. Carl St. Louis	190
Howell, Billy D. Brookfield	078
Humphrey, James D. Mound City	158
Karraker, Alvan G. Farmington	138
Kauffman, Ruth Versailles	120
Lankford, Harold D. Mexico	014
Lichty, Charles A. Shelbina	150
***Lillig, James F.** Kansas City	050
Long, Curtis W. Butler	214
Magaw, David C. Everton	066
Magruder, Lyell M. Nevada	214
***Martin, Kevin J.** Vandalia	014
McFadden, Gene A. Waverly	118
Menne, Marvin C. Ironton	138
Moore, Candice A. Nevada	214
Moore, Michael R. West Plains	206
Morehead, William E. Malden	070
Morris, John J. Columbia	026
Painter, Andrew E. Portageville	202
Pavlu, Robert R. Waverly	118
Pehlman, Joseph E. Malden	070
Raynor, Richard C. Marshall	198
Reed, Glen H. Appleton City	214
Sargent, Alden P. Sikeston	202
Schaaf, Robert O. St. Joseph	030
Scowley, John E. Richmond	118
Shanahan, Philip J. St. Louis	190
Singh, Daljeet R. Higginsville	118
Taylor, Steve J. Mexico	014
Won, Russell St. Louis	190

General Surgery (GS)

Aeder, Mark I. Kansas City	125
Afuwape, Emanuel A. E. St. Louis, IL	190
Albano, Benjamin I. Crystal City	106
Altepeter, H. Martin St. Louis	190
Andres, Edward H. St. Joseph	030
Apostol, Andres G. Monett	166
Arbab, Ali A. Kansas City	125
Arenos, Proceso T. St. Louis	190
Arnold, Kenneth J. Chesterfield	190
Ashley, Michael E. Springfield	082
Ayvazian, Vatche H. St. Louis	190
Barker, Patricia L. Hannibal	150
Barragan, Hector D. St. Louis	190
Bartlett, Hugh C. Rolla	135
Bass, Barry J. Rolla	135
Bauer, Joseph G. Hannibal	150
Bautista, Joel O. Moberly	046
Bautista, Rogelio L. Moberly	046
Beckman, Robert F. St. Louis	190
Beggs, Charles W. Liberty	050
Beheler, Edward M. St. Joseph	030
Behrends, Steven H. Kansas City	125
Bennett, Kenneth J. St. Louis	190
Bentlage, Charles H. Joplin	102
Bergmann, Daniel J. St. Peters	189
Berwald, David M. Bridgeton	190
Betz, Robert F. Neosho	166
Bhattacharya, Arjun St. Louis	190
Billy, Lawrence J. St. Louis	190
Birnbaum, Elisa H. St. Louis	190
Bizek, J.L. Aurora	166
Blake, Kathleen M. Columbia	026
Blanke, Thomas J. St. Louis	190
Branch, Walter D., Jr. Kansas City	002
Braverman, Stuart J. Sedalia	178
Buchele, Alan Morrow Joplin	102
Buckner, John W. Springfield	082
Buettner, John Brigham Chesterfield	190
Bukstein, Michael J. Hannibal	150
Bussmann, Carl E. Bridgeton	190
Cabrera, Tomas V. St. Peters	189
Cardwell, Daniel R. Bolivar	066
Cassat, James D. Washington	207
Castaneda, Marco A. Bridgeton	190
Christiansen, Stephen D. Springfield	082
Christy, John P. Poplar Bluff	034
Chu, Peter Y. Kansas City	125
Chung, T. David Poplar Bluff	034
Codd, John E. Bridgeton	190
Coe, Douglas A. Kansas City	002
Cohen, Max M. St. Louis	190
Corrado, Joseph A. Mexico	014
Corry, Francis M. Springfield	082
Cox, Kurtis S. Joplin	102
Craighead, Michael L. Jefferson City	058
Creswell, Lawrence L. Chesterfield	190
Critchlow, J. Thomas Cape Girardeau	042
Daake, John W., Jr. St. Louis	190
Dandridge, Walter C. Joplin	102
Doerhoff, Carl R. Jefferson City	058
Donovan, John F. St. Louis	190
Eck, Bryan D. West Plains	206
Elfrink, Roy J. Marshall	198
Esparrago, F.R. Monett	166
Evans, Joseph C., Jr. Independence	125
Fabito, Daniel C. St. Louis	190
Fahrner, Mari A. Chesterfield	190
Floro, Kenneth E., Jr. St. Louis	190
Floro, Mariano N. Florissant	190
Foley, Jonathon K. Cape Girardeau	042
Foreman, Phillip B. Hannibal	150
Gerowin, Lance St. Louis	190
Gibson, James D. Springfield	082
Gieselmann, James W. Poplar Bluff	034
Glenn, Edward A., III Louisiana	150
Gomez, Cesar A. St. Louis	190
Graff, Ralph J. St. Louis	190
Guerra, Gaston G. Kansas City	125
H'Doubler, Charles Mt. Vernon	082
H'Doubler, Peter B. Springfield	082
Hanson, Morin M. St. Louis	190
Harms, James Nevada	214
Harris, Hugh S., Jr. Columbia	026
Hayek, Michael E. St. Louis	190
Helling, Thomas S. Kansas City	125
Hill, Ronald T. Dexter	002
Hiser, Christy J. Branson	208
Hoberock, Thomas R. Branson	208
Hoehn, John P., III St. Louis	190
Hornbostel, Phillip M. Sedalia	178
Hunt, Robert S. Cape Girardeau	042
Ivins, Gregory K. Fulton	038
James, Kathleen M. St. Charles	189
James, Kelly M. Independence	125
Jensen, Joshua E., II St. Louis	190
Jew, Amie C. Overland Park, KS	125

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GENERAL SURGERY

Johnson, Frank E. St. Louis	002
Joyce, Rex M. Kansas City	125
Kang, Young M. West Plains	206
Kasten, Melvin C. Cape Girardeau	042
King, Frank K. Hayti	170
Kingsbury, Robert J. St. Peters	189
Knight, James W. St. Louis	190
Koivunen, Debra G. Columbia	026
Krajcovic, David P. Chesterfield	190
Kurzweil, Steven L. Festus	106
Kuvshinoff, Boris W. Columbia	026
Larson, Kenneth W. Springfield	082
Laster, Jerry L. Joplin	102
LaHue, William C. Lexington	118
Liang, Jing C. Independence	125
***Light, Diane L.** Jefferson City	058
Londe, Alan M. St. Louis	190
Long, W. Steven St. Joseph	030
Lopez-Plata, Roberto Leawood, KS	125
Ludwig, Mark St. Louis	190
Lundman, Hugh Springfield	082
Madrid, Dominador O. St. Louis	190
Mahoney, Kevin R. Springfield	082
Martin, Clarence A. Joplin	102
McClune, Grant L. Cape Girardeau	042
McCroskey, Lon C. Kansas City	125
McGinty, Frank H. Cape Girardeau	042
McGregor, Patrick E. N. Kansas City	050
Meier, Mitchell S. Joplin	102
Memmolo, Ciriaco A. St. Louis	190
Metzler, Michael H. Columbia	026
Meyer, Robert C. St. Louis	190
Meyers, Jerry R. St. Peters	189
Miedema, Brent W. Columbia	026
Miller, Thomas A. St. Louis	002
Mitchell, Franklin L. Columbia	026
Moffe, Thomas C. Springfield	082
Morehouse, Paul D. Warrensburg	110
Mosley, Julian C. St. Louis	190
Muhm, H. Yale St. Charles	189
Mutchnick, Norman Kansas City	125
Nagle, Michael G. Joplin	102
Nathan, Lester J. Fenton	190
Near, David M. Florissant	190
Newman, Joseph A. Joplin	102
Niesen, Frank J. St. Louis	190
Niesen, Thomas E. Chesterfield	190
Nigro, Thomas L. Kansas City	125
Nwaobasi, Sam Florissant	190
Occeno, Victor G. Cassville	166
Ochoa, Pedro Valmeyer, IL	190
Oliver, George A. Farmington	138
Olson, Richard O. St. Charles	189
Parikh, Sharad P. Florissant	190
Parks, Charles St. Louis	190
Parulekar, Dilip G. Fulton	038
Peick, Ann L. St. Louis	190
Pennell, Richard C. St. Louis	190
Perll, Peter D. Mexico	014
Petelin, Joseph B. Shawnee Mission, KS	125
Peters, Walter R. Columbia	026
Petit, Carl A. Osage Beach	120
Philpott, Gordon W. St. Louis	190
Pitsinger, N. Bruce Chesterfield	190
Porvaznik, John T. Chesterfield	190
Prasad, Chandra N. Jefferson City	058
Previti, Vincent Springfield	082
Pruett, Don S. St. Louis	190
Radford, Diane M. St. Louis	190
Rao, Ricardo Chesterfield	190
Reardon, Thomas M. Liberty	050
Reese, Jon A. Springfield	082
Reister, Philip D. Kansas City	125
Rendleman, George F., Jr. St. Louis	190
Richardson, Donna T. Union	207
Richardson, Norbert L. Union	207
Richmond, Ron Cape Girardeau	042
Riechers, Thomas B. Washington	207
Roberts, Jonathan M. Jefferson City	058
Roh, Joseph J. Kansas City	125
Safley, Thomas J. Independence	125
Schaefer, Glennon S. St. Louis	190
Schiro, John E. Cameron	054
Schlarman, David E. St. Louis	190
Schneider, Thomas A. St. Charles	189
Schokker, Johannes Jefferson City	002
Schuh, Marlys E. Creve Coeur	190
Scott, Joni C. Rogersville	082
Sharlow, Joseph W. Ste. Genevieve	174
Shine, Thomas E. St. Louis	190
Shoults, Nicholas F. Springfield	082
Smith, Kenneth G. St. Louis	190
Spadone, Donald P. Columbia	026
Spehar, Pascal E. Independence	125
Stam, M. Denton Springfield	082
Standiford, Steven B. Columbia	026
Starke, Joe D. Columbia	026
Steiling, Sylvia A. St. Louis	190
Sugarbaker, Stephen P. Jefferson City	058
Switzner, Diane L. Springfield	082
Tang, Teodoro Salem	135
Tenorio, Arturo A. Stanberry	158
Terry, Boyd E. Columbia	026
Terschluse, David A. Bridgeton	190
Thornton, Fred H. Sikeston	202
Trinidad, Hermanito R. Chillicothe	078
Troop, Bryan R. St. Louis	190
Tucker, George L. Town & Country	002
Turner, William A. Nevada	214
Underwood, Johnson, III N. Kansas City	050
Verzola, Eufemio G. Herculaneum	106
Vetsch, Raymond Joplin	102
Vitale, Thomas J., Jr. St. Louis	190
Wade, Scott A. St. Joseph	030
Wadley, Jeff Sedalia	178
Webb, John M. Kansas City	125
Werner, F. Scott N. Kansas City	050
Westerman, Robert N. St. Louis	190
Westfall, Scott G. Chesterfield	190
Westfall, Susan H. St. Louis	190
Wetzel, C. Robert Clinton	086
Wetzel, Gus S. Clinton	086
Wilbers, Raymond H. Mexico	014
Willcoxon, Robert L. Joplin	102
Wittmer, Marc R. Springfield	082
Wonder, Donald Branson	208
Zacharias, Kulangara P. Columbia	026

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Gynecology (GYN)

Alderman, Lillian C.	050	Liberty
Byers, Lowell J.	125	Leawood, KS
Grimes, Elwyn M.	125	Kansas City
Patterson, Donald C.	026	Columbia
Roberts, Howard H.	102	Joplin
Schmidt, Herbert J.	102	Joplin
Williams, Carol F.	190	St. Louis

Hand Surgery (HS)

Towle, Dana R.	050	N. Kansas City
Wyrsch, Bradley	082	Springfield

Head & Neck Surgery (HNS)

Seabaugh, Janice L.	042	Cape Girardeau
Sudekum, Anthony E.	189	Defiance

Hematology (HEM)

Abbey, Elliot E.	002	St. Louis
Carden, Juan O.	190	St. Louis
Carter, Robert L.	102	Joplin
Davidner, Mark L.	125	Kansas City
Davis, Kimberly K.	125	Independence
Geier, Larry J.	125	Kansas City
Gomez, Patrick L.	082	Springfield
Grant, Ruth	082	Springfield
Loftus, Loretta S.	125	Kansas City
Monaghan, Greg G.	026	Columbia
Muscato, Joseph J.	026	Columbia
Muscato, Mary S.	026	Columbia
Peterson, Jay T.	125	Kansas City
Ratkin, Gary A.	190	St. Louis
River, George L.	102	Joplin
Sirridge, Marjorie J.	125	Kansas City
Trendle, Michael C.	058	Jefferson City
Vellek, Mark J.	026	Columbia
Weigand, Robert T.	030	St. Joseph
Woodson, Mark E.	190	St. Louis

Hematology/ Oncology (HO)

Chan, Celia L.	042	Cape Girardeau
Sides, Stanley D.	042	Cape Girardeau
Yuen, Benjamin H.	042	Cape Girardeau

Infectious Diseases (ID)

Brewer, Joseph H.	125	Kansas City
Driks, Michael R.	125	Kansas City
Grieshop, Theodore J.	042	Cape Girardeau
Haddow, Alastair D.	082	Springfield
Hagan, Margaret E.	125	Independence
Henry, R. Beth	125	Kansas City
Hinrichs, James H.	190	Bridgeton
McKinsey, David S.	125	Kansas City
Neihart, Robert E.	125	Kansas City
Sistrunk, William W.	082	Springfield
Smith, David Lambuth	125	Kansas City
Spernoga, John F.	190	St. Louis
Winton, Mark D.	058	Jefferson City

Internal Medicine (IM)

Abel, Charles C.	190	St. Louis
Abinoja, Conrado B.	190	St. Louis
Adiga, Raghavendra B.	010	Savannah
Ahadi, Abd U.	190	St. Louis
Ahern, Archibald M.	190	St. Louis
Ahmad, Musaddeque	138	Potosi
Ahmad, Naseer	190	St. Louis
Albano, Grace A.	125	Lee's Summit
Alegre, Jorge M.	190	Chesterfield
Allen, Thomas P.	125	Overland Park, KS
Allyn, Steven L.	082	Springfield
Almond, Toni	026	Columbia
Alvarez, Juan M.	190	Florissant
Alvarez, Ulises C.	190	Florissant
Anderson, Clay M.	026	Columbia
Andrews, Paul E.	082	Springfield
Anslinger, David L.	190	Chesterfield
Arquette, Matthew A.	002	St. Louis
Arvan, Andrea	125	Kansas City
Atkinson, John P.	190	St. Louis
Avioli, Louis V.	190	St. Louis
Azan, Kenneth N.	178	Sedalia
Baak, Steven W.	190	St. Louis
Back, Donald K.	082	Springfield
Baird, John B.	026	Columbia
Baker, Eric K.	002	Kansas City
Baker, Tim E.	207	Washington
***Balcer, Conrad S.**	058	Jefferson City
Barjenbruch, Peggy W.	014	Mexico
***Barrow, Chelmer L., Jr.**	190	Lake St. Louis
Bartell, Michael F.	190	St. Louis
Bauer, Daniel J.	190	St. Louis
Bauer, John H.	026	Columbia
Bautz, James B.	125	Kansas City
Bauwens, Daniel B.	190	Chesterfield
Becker, Gregory L.	190	St. Louis
Benedict, William W.	190	Chesterfield
Bentley, John D.	082	Springfield
Berkowitz, Ellis R.	030	St. Joseph
Bernstein, Aaron M.	190	St. Louis
Best, John A.	190	Chesterfield
Bettonville, Peter V.	190	St. Louis
Biggs, Alfred D., Jr.	125	Kansas City
Blatt, Carl F.	207	Washington
Blum, Donald A.	190	St. Louis
Boldt, Thomas H.	190	Bridgeton
Bonsanti, Robert L.	190	Bridgeton
Borowsky, Benjamin A.	190	St. Louis
Bowe, Christopher C.	190	St. Louis
Bowles, G.R.	190	St. Louis
Brady, Timothy T.	190	St. Louis
Bregant, Robert E.	058	Jefferson City
Breite, Warren M.	106	Festus
Broaddus, Loren E.	082	Springfield
Brockman, M. Douglas	082	Springfield
Brody, Arnold G.	190	St. Louis
Brown, Barry D.	190	St. Louis
Brumfield, Amy	126	Murray, KY
Burns, Edward L.	190	St. Louis
Burns, Thomas W.	026	Columbia
Buse, Paul E.	190	St. Louis
Butin, Richard E.	125	Kansas City
***Byrne, Kevin G.**	120	Osage Beach
Cabral, G.	190	Florissant
Cadiz, Briccio S., III	174	Ste. Genevieve
Camp, Alan D.	002	St. Louis
Campbell, J. William	190	St. Louis

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*Doctor of Osteopathy

INTERNAL MEDICINE

Cara, Elma E.	002	St. Louis
Carmichael, Kim A.	190	St. Louis
Carmody, John P.	190	St. Louis
Caruso, A. Cosmo	125	Kansas City
Cary, John M.	190	Chesterfield
Caster, John P.	115	Lebanon
Chandramohan, Nanjappa	102	Carthage
Chase, Larry K.	082	Springfield
Chern, Mou S.	206	Ava
Chouinard, Michael P.	202	Sikeston
Clark, David P.	026	Columbia
Clark, Lin Wu	125	Independence
Clayton, William L., III	135	Duke
Coates, James G.	002	St. Louis
Cochran, Calvin D.	125	Kansas City
***Cohen, Donald L.**	125	Overland Park, KS
Cohen, Hillard K.	190	St. Ann
Conger, Susan C.	190	St. Louis
Convery, Paul B.	190	St. Louis
Coppinger, Thomas A.	125	Kansas City
Corder, James C.	190	St. Louis
Costello, John B.	190	St. Louis
Crespin, Stephen R.	190	St. Louis
***Crowell, Tamara E.**	125	Lee's Summit
Cruz, Sergio G.	166	Monett
Cryer, Philip E.	190	St. Louis
Cummings, Steven W.	190	Brentwood
Cunningham, Edwin J.	190	Chesterfield
Curry, Michael J.	189	St. Charles
***Daly, Michael M.**	026	Columbia
Daniels, John S.	002	St. Louis
Danuser, Carol B.	026	Columbia
Davis, John M.	125	Kansas City
Deckard, Shelby W.	082	Springfield
Delcambre, Marie A.	125	Kansas City
Delwood, Don M.	026	Columbia
Dew, Thomas A.	190	Chesterfield
Dexter, J. Kent	082	Springfield
DeBelen, Arnold Z.	150	Canton
DeCastro, Edna C.	078	Chillicothe
DeFeo, Frederick G.	125	Kansas City
Diemer, Thomas S.	042	Cape Girardeau
Diestelhorst, James A.	190	St. Louis
DiPasco, Donald J.	190	St. Louis
DiValerio, Richard M.	190	St. Louis
Dorton, Robert K.	190	St. Louis
Dorzab, Linda L.	125	Stilwell, KS
Dotson, Lori J.	026	Boonville
Downing, Pamela J.	026	Boonville
Enriquez, Roman S.	125	Kansas City
Ervin, John E.	125	Kansas City
Etienne, Robt B.	190	St. Louis
Evans, Andrew L.	002	Springfield
Farrell, Thomas M.	002	St. Louis
Favors, Adolphus C., Jr.	190	St. Louis
Fischer, Robert	190	St. Louis
Fitch, Coy D.	190	St. Louis
Fleming, David A.	026	Moberly
Fleming, J. Will, Jr.	046	Moberly
Flotte, Sylvester A.	190	St. Louis
Flury, Kirk E.	190	St. Louis
Fogarty, William M., Jr.	190	St. Louis
Fortunato, Vincent P.	002	St. Louis
***Frank, Robert A.**	125	Independence
Fraser, Victoria J.	190	St. Louis
Frey, Jeffrey P.	026	Columbia
Froehlich, Thomas W.	082	Springfield
Gale, Arthur H.	190	St. Louis
Galvez, Sisenando P.	078	Marceline
Garcia, Kathleen M.	190	St. Louis
Garfinkel, Bernard T.	190	St. Louis
Garriga, Francisco J.	190	Florissant
Gatchalian, Felicitas Z.	190	St. Louis
Geier, David L.	082	Springfield
Gendel, Jonathan	125	Lee's Summit
Gentsch, Kenneth W.	190	St. Louis
Ghazal-Albar, Naman	150	Louisiana
Ghosh, Nillima N.	190	St. Louis
Gill, Paul J.	082	Springfield
Ginther, James W., Jr.	190	St. Louis
Giorgi, Lee V.	125	Kansas City
Glaser, Max	125	Kansas City
Glazer, Melvin L.	125	Kansas City
Godwin, Lehman W.	082	Springfield
Golder, Robert	125	Kansas City
Goldman, Arnold M.	190	St. Louis
Goodenberger, Daniel M.	190	St. Louis
Goodwin, J. Wendall	082	Springfield
Gould, Ronald J.	190	St. Louis
Grady, Ronald K.	190	Chesterfield
Gray, Gary J.	190	St. Louis
Greenlaw, Cal W.	078	Chillicothe
Gregory, Mark H.	190	St. Louis
Griesbaum, Robert V.	190	St. Louis
***Gryte, Rolf R.**	120	Osage Beach
Gupta, Vicram	030	St. Joseph
Gutierrez, Ernesto	190	Florissant
Guyol, William B., Jr.	190	St. Louis
Gwin, Edward	082	Springfield
Hagen, Garrett A.	190	St. Louis
Haight, Randall D.	058	Jefferson City
Hale, Thomas H.	190	Manchester
Halpin, Stephen E.	150	Hannibal
Hamburg, Eric D.	138	Farmington
Hamid, Zahid	158	Mound City
Hamly, Frederick N.	135	Rolla
Hammerman, Marc R.	190	St. Louis
Hardy, Patrick J.	190	Florissant
***Harris, William D.**	125	Lenexa, KS
Hassan, Anisa	102	Joplin
Hawatmeh, Sam	190	St. Louis
Hegde, Korgi V.	190	St. Louis
Heins, James N.	190	St. Louis
Hellam, Duane C.	082	Springfield
Henry, Joseph E.	050	Shawnee Mission, KS
Herfkens, Kenneth D.	082	Springfield
Hignight, James E.	125	Platte City
Hill, M. Robert	190	St. Louis
Himes, Joyce B.	082	Springfield
Hintze, Paul F.	190	St. Louis
Hodge, Robert H., Jr.	026	Columbia
Hoeman, Michael D.	082	Springfield
Hoeper, Samuel D., Jr.	125	Kansas City
Hoffman, Leanna M.	078	St. Joseph
Hoffmann, Sandra S.	190	Chesterfield
Hogan, John R.	190	St. Louis
Holkins, John M.	125	Kansas City
***Hon, Sarah Jane**	050	Liberty

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Hu, Raymond J. St. Peters	189
Huck, Richard F., Jr. St. Louis	190
Hudgins, Marianne B. Kansas City	125
Husted, Frederick C. Springfield	082
Inman, Max M. Chesterfield	190
Irvin, William S. Columbia	026
Jain-Roberts, Sangeeta Jefferson City	058
***James, Donald L.** Rolla	135
Jantz, Keith Kansas City	125
Jarvis, Cathy C. Florissant	190
Javdan, Ron St. Louis	190
Jayamanne, Damasus S. Jefferson City	058
Jedlinski, Michael T. Cape Girardeau	042
Johnson, Eric J. Chesterfield	002
Johnson, Kevin T. Bridgeton	190
Jones, David K. Mexico	014
Josyula, Bhagavan V. St. Louis	002
Jotte, Richard P. St. Ann	190
***Joubert, Paul M.** Lee's Summit	002
Juergens, William G. St. Louis	190
Kanagawa, Harold K. Jefferson City	058
Kandula, Madhavi St. Louis	190
Kardesch, Milton St. Louis	190
Karsh, Robert S. St. Louis	190
Kaufman, Robert L. St. Louis	190
Kauk, Bruce A. N. Kansas City	050
Kaup, Chandra S. Florissant	190
Kelly, John J. St. Louis	190
Kerkemeyer, George Hannibal	150
Kichura, George M. St. Louis	190
Kim, Chul Poplar Bluff	034
King, Tinna P. St. Louis	190
Kinsella, Peter W. St. Louis	190
Kipnis, David M. St. Louis	190
Kirkland, Jerry A. Kansas City	050
Kissell, Richard W. Springfield	082
Klearman, Micki St. Louis	190
Knight, William A., Jr. St. Louis	190
Knowlton, Norman P., III Springfield	082
Kolb, Lisa G. Jefferson City	058
Kosloff, Alex H. St. Louis	190
Kreski, Kenneth C. House Springs	190
Krewet, Frank A., III St. Louis	190
Kriegshauser, James W. St. Louis	190
Kuangparichat, Manoch Excelsior Springs	118
Kunst, Edward J. Manchester	190
Laird, John M. St. Louis	190
Landau, David W. St. Louis	190
Landsbaum, Charles J. Jefferson City	058
***Lange, John F.** Lake Ozark	058
Lauer, Danl J. Overland Park, KS	125
LaMonda, Gary W. Columbia	026
Leeper, Sidlee W. Rocheport	026
Leitch, Steven M. Springfield	082
Letizia, Wayne L. Independence	125
Lewandowski, Molly J. Leawood, KS	125
Lila, Aram Excelsior Springs	050
Lilly, Douglas R. St. Louis	190
Lin, H.T. Moberly	046
Lockard, Orlyn O. St. Joseph	030
Loeb, Richard H. Springfield	082
Long, Priscilla E. Hannibal	150
Lovinger, Warren C., Jr. Nevada	214
Lyons, Daniel F. Springfield	082
Lyss, Carl A. St. Louis	190
Maben, Pamela S. Independence	125
Maben, Sam E. Kansas City	125
Mack, Marvin L. Columbia	026
Macleod, Angus St. Louis	190
MacGorman, Linda R. Springfield	082
Majors, Patrick F. St. Louis	190
Maliszewski, James A. Kansas City	125
Mallouk, Alexander G. Kansas City	125
Mantell, Jack M. Springfield	082
Margolis, David M. St. Louis	190
Martin, Chris J. Columbia	026
Mass, Joan H. St. Louis	190
Mathews, Jeffrey E. St. Louis	190
Mayus, Joseph L. Springfield	082
McCarthy, Christopher E. St. Louis	190
McCormack, Robert E. Kansas City	125
McDonald, James H. Kansas City	125
McDonald, Wallace St. Joseph	030
McGovney, Janice K. Kansas City	050
McKeel, Thomas B. Kansas City	125
McKinley, Lois J. Kansas City	125
McLemore, Willie O. Kansas City	125
McMahon, Robert St. Louis	190
McMillen, James J. St. Joseph	030
***McNabb, M. Jeffery** Cape Girardeau	042
McNay, Jennifer A. Springfield	082
Mehra, Ravi St. Louis	190
Meidl, Erik J. Hannibal	150
Meldi, Dominic M. Springfield	082
Meltz, Gary J. St. Charles	189
***Meyers, Sharon A.** St. Louis	190
Mihalevich, John A., Jr. Springfield	082
Miller, Dace L. Springfield	082
Miller, Donald Jefferson City	058
Minnigerode, Turner L. Kansas City	125
Miskovsky, Emil F. St. Louis	190
Mitchell, Lynn D. Columbia	026
Mohs, Frank R. St. Louis	190
Molden, C. Scott St. Louis	190
Monaco, Michael Harrisonville	125
Montgomery, Austin F. St. Louis	190
Moore, John M. Kansas City	002
Morgan, Vincent I. Columbia	026
Moriconi, William J. St. Louis	190
Motchan, Dennis G. Bridgeton	190
Muchnick, Richard L. St. Louis	190
Muegge, F. David Springfield	082
Mullen, Mary E. Mexico	014
Mullican, Charles N. St. Joseph	030
Nanson, Duane Columbia	026
Narayan, Dilip L. Chesterfield	190
Nelson, Donald C. Springfield	082
Nicholas, Stephen P. St. Louis	190
Nickell, Michael D. Joplin	102
Nicolazzi, Anne-Marie M. St. Louis	190
Niesen, Anna R. St. Louis	190
Nix, J. Gustavo Bolivar	066
Novack, Mark A. Chesterfield	190
Nye, Terry R. Springfield	082
O'Connor, Mary C. Kansas City	125
O'Donnell, Susan M. Ste. Genevieve	174
O'Dowd, Mary K. Chesterfield	002
O'Keefe, James H., Jr. Kansas City	125

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Ockner, Samuel A.	190	Chesterfield
Oertli, Robert	190	St. Louis
Olsen, Teresa A.	082	Springfield
Olson, James H.	050	Liberty
Orgel, S. Michael	190	St. Louis
Orlando, Louis A.	125	Lee's Summit
Ortbals, David W.	190	Chesterfield
Palaniappan, Meyyappan	034	Doniphan
Palazola, Joseph M.	125	Kansas City
Paletta, Frank	190	St. Louis
Paone, Douglas B.	125	Kansas City
Park, Duk J.	106	Festus
Parks, David A.	190	St. Louis
Parks, Deborah L.	190	St. Louis
***Pasowicz, Timothy C.**	125	Shawnee Mission, KS
Patel, Dilip H.	190	St. Louis
Patel, Indu B.	106	Barnhart
Peck, William A.	190	St. Louis
Pereira, MaryBeth	190	St. Louis
Perez, Robert J.	190	St. Louis
Perll, Michael F.	125	Kansas City
Perryman, J. Chris	125	Kansas City
Pfefferkorn, David A.	202	Sikeston
Phillips, William J.	190	Chesterfield
Pickering, Lee I.	125	Independence
Piening, Kurt A.	189	St. Charles
Pierce, Dan L.	026	Columbia
Pineda, Hector O.	190	St. Louis
Pineda, Juan J.	026	Columbia
Podolsky, Howard S.	002	St. Louis
Pogson, George W., III	125	Independence
Ponstingl, Raana J.	190	St. Louis
Popp, Dennis A.	190	St. Louis
Portwood, Glen L.	125	Kansas City
Postma, George S., Jr.	125	Mission, KS
Potts, Dan E.	190	Chesterfield
Powell, Kenneth R.	082	Springfield
Prelutsky, David J.	190	St. Louis
Proskey, Vincent J.	190	Chesterfield
Purcell, Henry E.	190	St. Louis
Purcell, Richard D.	082	Springfield
Puro, Edward A.	190	Florissant
Qureshi, Abdul R.	190	St. Louis
Raju, Niranjana	174	Ste. Genevieve
Randolph, Kerry A.	002	Springfield
Rangineni, Rajagopal	030	St. Joseph
Rau, Michael E.	207	Washington
Raybould, Michael W.	125	Kansas City
Rearden, Timothy P.	190	St. Louis
Reardon, Thomas F.	190	St. Louis
Redington, James C., Jr.	190	St. Louis
Redmon, Conchita M.	082	Springfield
Reh, Edward P., Jr.	190	St. Louis
Reiss, Jacqueline L.	190	Chesterfield
Rice, Karen H.	058	Jefferson City
Richards, Dean D., III	125	Overland Park, KS
Richardson, Christy L.	125	N. Kansas City
Riley, Joel Y.	002	St. Louis
Ring, Daniel S.	190	St. Louis
Riojas, Lisa A.	135	Rolla
***Rittman, Christopher J.**	208	Branson
Robinson, Nicholas F.	070	Kennett
Robison, Leon R.	190	Chesterfield
Rogers, James T.	082	Springfield
Rosecan, Marvin	190	Belleville, IL
Rosen, Larry A.	125	Independence
Rosenberg, David S.	190	Florissant
Ross, Robert M.	125	Kansas City
Rouse, Ernest T., III	190	St. Louis
Roxas, Generoso P.	189	St. Charles
Russell, John J.	042	Cape Girardeau
Sagar, Satya J.	190	St. Louis
Salibi, Habbouba	190	Chesterfield
Samet, John M.	190	St. Louis
Samuel, George P.	034	Doniphan
Sanchez, Archie J.	002	Overland Park, KS
Sandiford, Patrick	189	St. Charles
Sanfelippo, John F.	058	Jefferson City
Sargent, Jennifer E.	135	Rolla
Schell, James A.	026	Columbia
Scheperle, Mark A.	190	St. Louis
Schmid, Tania L.	190	St. Louis
Schmidt, Edwin H., III	190	St. Louis
Schnarr, William	189	St. Charles
Schneider, Paul G.	190	St. Louis
Schoenberger, John R.	042	Cape Girardeau
Schuessler, Wolfgang P.	190	St. Louis
Schwartzman, Neil R.	115	Lebanon
Scoles, Lyndell D.	026	Columbia
Scott, C. Alan	198	Marshall
Scott, Michael R.	082	Springfield
Scott, Robert W.	082	Springfield
Segall, Stephen A.	034	Poplar Bluff
Sertl, James F.	190	St. Louis
Shah, Riaz H.	014	Mexico
Shalet, Malcolm F.	125	Kansas City
Shen, Anthony S.	190	St. Louis
Shepard, Matthew D.	042	Cape Girardeau
Shireman, Frances	125	Kansas City
Shniter, Lorinna	190	St. Louis
Shuss, David H.	125	Kansas City
Siddiqui, Navid S.	138	Ellington
Silverstein, Randy B.	190	St. Louis
Singh, Kuldeep	046	Macon
Singleton, Charles M., II	125	Kansas City
Sislen, Donald R.	190	St. Louis
Sly, Anne K.	125	Kansas City
Smalling, Ronnie G.	002	Springfield
Smith, Kenneth B.	207	Washington
Smith, Timothy W.	125	Kansas City
Smoller, Martin B.	189	St. Louis
Sneid, David S.	125	Kansas City
Sollars, Eric G.	030	St. Joseph
Sosna, Jacob P.	190	St. Louis
Soucy, John C.	189	St. Charles
Spaedy, Tony	026	Columbia
Spearman, Michael L.	190	St. Louis
Spivack, Alan R.	190	Chesterfield
Sprague, Gita	030	St. Joseph
Spurgat, Robert M.	030	St. Joseph
Squitieri, Alphonse J.	190	St. Louis
Starke, Keith M.	002	St. Louis
***Steinbrecher, Janis M.**	125	Lee's Summit
Sterkel, Barbara B.	190	St. Louis
Sterkel, Richard L.	190	St. Louis
Stevens, Tracy L.	125	Kansas City
Stewart, James L.	050	Kansas City
Stiers, Julaine	026	Columbia

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*Doctor of Osteopathy

Stoffa, Maureen E.	190	St. Louis
Stone, Carissa M.	002	Kansas City
Strauss, Carl F.	125	Kansas City
Stronach, Linda L.	190	St. Louis
Stuber, Robert R.	030	St. Joseph
Suarez-Solar, Pedro L., Jr.	190	St. Louis
Subramanian, S.	102	Carthage
Sullivan, William W.	190	St. Louis
Suwannasri, Rudee	190	St. Louis
Swaykus, Bernard T.	190	Bridgeton
Sylvanovich, W. Richard	190	St. Louis
Tanphaichitr, Kongsak	190	St. Louis
Tansuwan, Chukiat	190	St. Louis
Tariq, Manzoor A.	190	Chesterfield
Taylor, William K.	082	Springfield
Tepper, Arnold	190	St. Louis
Thanawalla, Shaukat A.	014	Mexico
Thesing, John A.	125	Lenexa, KS
Thompson, Randall C.	125	Shawnee Mission, KS
Thomson, William M.	190	Chesterfield
Threats, Susan C.	190	St. Louis
Threlkeld, Kevin L.	002	Lake St. Louis
Thyssen, Erik P.	190	St. Louis
Titterington, Frank W.	125	Kansas City
Torontow, R. John	214	Nevada
Toubes, Daniel B.	125	Kansas City
Trentham, Orin P., III	102	Joplin
Trotter, W. Yates	082	Springfield
Trygg, Kelly A.	066	Bolivar
Tucker, Leslie E.	207	Washington
Uhrig, Jack R.	198	Marshall
VanGoidsenhoven, Guy E.	190	St. Louis
VanVoorn, Catherine M.	026	Columbia
Vaporean, Mark L.	026	Columbia
Varma, Devendra K.	034	Poplar Bluff
Vibulakaopun, Pairat	138	Bonne Terre
***Vogelsang, Judith K.**	125	Kansas City
Vogt, Douglas	026	Columbia
Wade, Kim C.	125	Kansas City
Wagan, Primitiva C.	190	St. Louis
Wald, Stanley M.	190	St. Louis
Walden, James M.	125	Kansas City
Walker, Harvey, Jr.	190	St. Louis
Walker, Melvin O., Jr.	082	Springfield
Walsh, James W.	190	St. Louis
Wantuck, Donald K.	082	Springfield
Weinstock, Leonard B.	190	St. Louis
Weiss, Peter D.	190	St. Louis
Welton, Stephen T.	202	Sikeston
Wethers, Darren E.	190	St. Louis
Weyerich, Noel F.	190	St. Louis
Whitman, Daniel S.	125	Kansas City
Whittaker, Thomas J.	125	Kansas City
Wilkins, Michael S.	125	Kansas City
Williams, R. Jerome, Jr.	190	St. Louis
Wilt, David A.	125	Kansas City
Winship, Daniel H.	002	Maywood, IL
Wolfe, John E.	082	Springfield
Woodley, Michele C.	190	St. Louis
Woolery, William G.	178	Sedalia
***Wright, Robert A.**	190	St. Louis
Wright, William P.	190	St. Louis
Wuellner, David H.	178	Sedalia
Wurster, Mark W.	125	Kansas City
Wurtz, Mary M.	125	Independence
Yerra, Shanti S.	082	Springfield
Yoxall, Kelly E.	125	Kansas City
Yu, Simon M.	190	St. Louis
Zerr, Charles H.	125	Independence
Zimmerman, Herbert B.	190	St. Louis
Zylka, J. Michael	190	St. Louis

Internal Medicine/ Pediatrics (MPD)

Aydt, Sarah A.	042	Cape Girardeau
Keithahn, Stephen T.	026	Columbia

Maternal & Fetal Medicine (MFM)

Amon, Erol	190	St. Louis
Dix, Patricia M.	082	Springfield
Hess, L. Wayne	026	Columbia
Sunderji, Shiraz	190	St. Louis

Maxillofacial Surgery (MFS)

Cornella, Frank A.	082	Springfield
Gipson, J. David	082	Springfield

Neonatal-Perinatal Medicine (NPM)

Pettett, Gary	125	Kansas City
Thibeault, Donald W.	125	Kansas City

Nephrology (NEP)

Aboul-Magd, Ahmed	042	Cape Girardeau
Benson, Larry E.	050	N. Kansas City
Birenboim, Nancy	125	Kansas City
Braxton, Frank W.	042	Cape Girardeau
Dobyan, Dennis C.	030	St. Joseph
Garcia, Juan C.	190	St. Louis
Langley, Harriet S.	125	Kansas City
Mir, A. Rauf	125	Kansas City
Redington, James C.	050	N. Kansas City
Sivarajan, Subramanian	125	Kansas City
Thomas, Alexis G.	125	Kansas City
Winkelmeyer, William K.	026	Columbia
***Young, Michael A.**	058	Jefferson City

Neurology (N)

Abrams, Bernard M.	125	Kansas City
Adelmann, Eugene	190	St. Louis
Allen, Arthur A., II	125	Shawnee Mission, KS
Applegate, Clara	206	West Plains
Arkin, Steven M.	125	Kansas City
Arora, Ravinder S.	178	Sedalia
Asher, Irving M.	026	Columbia
Awadalla, Sylvia	190	St. Louis
***Belson, Ian L.**	125	Kansas City
Bettinger, Irene E.	125	Kansas City
Bhothinard, Bhisit	034	Poplar Bluff
Brownsworth, Ronnie D.	082	Springfield
Carter, Dale M.	082	Springfield
Choi, Dennis W.	190	St. Louis
Cooper, V. Kent	125	Kansas City
Cuddihee, Robert E.	190	St. Louis
Dean, Philip D.	189	Lake St. Louis
Dexter, James D.	026	Columbia
Dobmeyer, Susan M.	190	St. Louis
Duffield, Jay C.	102	Joplin
Dysart, Dorsey W., Jr.	082	Springfield
Goldring, James M.	190	St. Louis

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Hanaway, Joseph St. Louis	190
Hardin, William B., Jr. Manchester	190
Hatlelid, J. Michael St. Louis	190
Hoffmann, Lee M. Shawnee Mission, KS	125
Hogan, Patrick A. St. Louis	190
Hooshmand, Ahmad Jefferson City	058
Horenstein, Simon St. Louis	190
***Hosley, Brett D.** Hannibal	150
Kader, Gihan A. Chesterfield	190
Lee, David Y.S. Cape Girardeau	042
Lin, Chi-Hsi Springfield	082
Luzecky, Michael H. Springfield	082
Makos, Mignon M. St. Joseph	030
Margolis, Robert P. St. Louis	190
Matovich, Violet B. Kansas City	125
McLaren, David L. Columbia	026
***Mellies, Steven D.** Cape Girardeau	042
Myers, Gary H. Chesterfield	190
Otto, Steven M. Springfield	082
Peeples, David M. St. Louis	190
Pentella, Karen J. St. Louis	190
Phillips, Daniel St. Louis	190
Quinn, Rodney D. Springfield	082
Reisler, David M. Chesterfield	190
Reiss, Jeanne E. Kansas City	125
Robinson, Jay G. Independence	125
Rosenbaum, Herbert E. St. Louis	190
Rowe, Vernon D., III Kansas City	125
Rymer, Marilyn M. Kansas City	125
Sahota, Pradeep K. Columbia	026
Schultz, Earl R. St. Louis	190
Selhorst, John B. St. Louis	190
Sher, Allyn L. Columbia	026
***Sherrod, Glenn M.** Bridgeton	190
Shuter, Eli St. Louis	190
Simowitz, Fredric M. St. Charles	189
Sohn, Richard St. Louis	190
***Stahly, Randall L.** Cape Girardeau	042
***Turpin, F. Duane** Bridgeton	190
Weinstein, Charles L. Kansas City	125
Weiss, Howard St. Louis	190
Weiss, Stuart St. Louis	190
Yanover, Robert A. St. Charles	190
Yu, Mario K. Kansas City	125

Neurology/ Diagnostic Radiology/ Neuroradiology (NRN)

Diemer, David P. St. Louis	190
Levine, Richard S. St. Louis	190
Thomasson, Jeffrey L. St. Louis	190

Neurological Surgery (NS)

Albanna, Faisal J. St. Louis	190
Backer, Robert J. St. Louis	190
Bailey, Gregory J. St. Louis	190
Blatt, Geoffrey L. Kansas City	125
Boland, Michael F. Chesterfield	190
Bondurant, Charles P. Columbia	026
Briggs, Thomas B. Springfield	082
Bucholz, Richard D. St. Louis	190
Camarata, Paul J. Kansas City	125
Cheung, K. Charles Cape Girardeau	042
Chicoine, Michael R. St. Louis	190
Chilton, Jonathan D. Kansas City	125
Colapinto, Edward V. Columbia	026
Cole, Harry O. Chesterfield	190
Cox, Curtis S. Jefferson City	058
Coxe, William S. St. Louis	190
Crafts, David St. Louis	190
Dacey, Ralph G., Jr. St. Louis	190
Daus, Arthur Steven Joplin	102
Ditmore, Q. Michael Columbia	026
Dowling, Joshua L. St. Louis	190
Dunn, Robert C., Jr. Washington	190
Ferguson, John F. Springfield	082
Gall, Clifford M. Kansas City	125
Gibbs, Scott R. Cape Girardeau	042
Gold, Jonathan A. St. Louis	190
Grubb, Robert L., Jr. St. Louis	190
Hanson, E. Jerome Kansas City	125
Hoffman, William F. St. Louis	190
Hornig, Gregory W. Kansas City	125
Jimenez, David F. Columbia	026
Kaufman, Andrew B. Kansas City	125
Kaufman, Bruce A. St. Louis	190
Kennedy, David G. St. Louis	190
Kitchens, Daniel L. St. Louis	190
Krettek, John E. Chesterfield	190
Madsen, Parley W. St. Louis	190
Majzoub, Hish S. Joplin	102
Marchosky, J. Alex Chesterfield	190
Martin, Stanley B. St. Charles	190
Mendelsohn, George E. Chesterfield	190
Mollman, H. Dennis Chesterfield	190
Morantz, Robert A. Kansas City	125
Mujica, Patricio H. St. Joseph	030
Nichols, Margaret E. Joplin	102
Oro, John J. Columbia	026
Park, Kee B. Cape Girardeau	042
Picker, Selwyn St. Louis	190
Pittmann, Thomas St. Louis	190
Ray, Joel W. Cape Girardeau	042
Reintjes, Stephen L. N. Kansas City	125
Rich, Keith M. St. Louis	190
***Routsong, Rodney T.** St. Louis	190
Scodary, Daniel J. Bridgeton	190
Shealy, C. Norman Fair Grove	082
Sheehan, Paul J. Bridgeton	190
Sherrill, Joseph E. St. Louis	190
Smith, Kenneth R., Jr. St. Louis	190
Stohr, Paul E. St. Charles	190
Walker, Gregory E. Independence	125
Whitlock, C. Courtney Springfield	082
Wilkinson, David St. Louis	190
Yingling, David G. Cape Girardeau	042
Yoon, Kong-Woo St. Louis	190
Young, Paul H. St. Louis	190

Neuroradiology (RNR)

Anderson, David R. Cape Girardeau	042

Nuclear Medicine (NM)

Egbert, Robert N. Springfield	082
Ho, Judith E. St. Louis	190
Long, Stephen E. Springfield	082
Siegel, Barry A. St. Louis	190

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Nuclear Radiology (NR)

Mosher, Amy A.	190	St. Louis

Obstetrics & Gynecology (OBG)

Ahlum, Sandra J.	150	Hannibal
Ahmad, Nusrat J.	190	Chesterfield
Anstey, John T.	190	St. Ann
Appelbaum, John K.	190	St. Louis
Azan, Abraham N.	178	Sedalia
Baalmann, Laura A.	190	St. Louis
Bagwe, Lata R.	190	St. Louis
Bale, Robert D.	190	St. Louis
Barlet, Elizabeth	102	Joplin
Batts, Barbara A.	125	Kansas City
Baumann, Daniel J.	190	St. Louis
Becker, Robert L.	190	St. Louis
Beckmann, Charles R.B.	125	Kansas City
Beguin, Everett A., Jr.	082	Springfield
Behrend-Uhls, Ann E.	042	Cape Girardeau
Belew, Joe E.	190	Chesterfield
Benson, Ronald G.	082	Springfield
Benton, Mary Beth	026	Columbia
Bever, Grant A.	190	St. Louis
Blaskiewicz, Robert J.	190	St. Louis
Boedeker, James P.	190	St. Louis
Borello, Dan J.	102	Joplin
Botney, Kathryn	190	St. Louis
Boveri, Lawrence V.	002	St. Louis
Boyd, Craig W.	190	St. Louis
Brennan, James M.	190	St. Louis
Brennan, Richard X.	190	St. Louis
Brennan, Robert A., Jr.	190	St. Louis
Brown, Cynthia L.	034	Poplar Bluff
Brown, Robert J.	189	St. Charles
Bruno, Patrick L.	002	Granite City, IL
Burks, Michael L.	026	Columbia
Burstein, Robert	190	St. Louis
Callaghan, Gerard M.	190	St. Louis
Camejo, Manuel	082	Springfield
Cannon, Jenifer M.	190	St. Louis
Caputo, Cynthia J.	125	Raytown
Cargill-Hickman, Dianna L.	050	Liberty
Caruso, Peter J.	125	Kansas City
Casey, Arthur L.	190	St. Louis
Cernik, Christine C.	190	Chesterfield
Chesney, John W.	102	Joplin
Chirino, Octavio R.	190	St. Louis
Chod, Ronald J.	190	St. Louis
Clark, Larry K.	102	Joplin
Clarke, Paul W.	042	Cape Girardeau
Cooper, Robert L., II	110	Warrensburg
Coordes, Kathleen M.	190	St. Louis
Corder, Robert L.	030	St. Joseph
Cornwell, Karen R.	125	Kansas City
Cox, Jeffrey L.	102	Joplin
Crane, James P.	190	St. Louis
Dagartzikas, A. K.	190	St. Louis
Dahm, Charles H., Jr.	190	St. Louis
Davidson, Raymond P.	190	St. Louis
Davis, Cynthia L.	150	Hannibal
Dement, Oman E.	102	Joplin
DeUngria, Pablo C.	190	Bridgeton
Dieterich, Russell B.	189	St. Charles
Doan, Laura B.	125	Raytown
Driskell, Karen K.	125	Kansas City
Durel, Justin H.	190	St. Louis
Eachempati, Uma R.	190	Arnold
Easley, Kevin O.	190	St. Louis
Eaton, Paula	125	Kansas City
Ekunno, Josiah O.	190	St. Louis
Fast, Robert E.	030	St. Joseph
Ferns, Francis E.	125	Kansas City
Ferris, Robert E.	058	Jefferson City
Fitts, Bill	214	Nevada
Fleer, Gerald K.	189	St. Peters
Fogle, Philip R.	082	Springfield
Friesen, Randall G.	189	St. Charles
Gardner, Joe A.	102	Joplin
Garrison, David L.	030	St. Joseph
Gay, John W.	026	Columbia
Gearhart, Beth J.	190	St. Louis
Gearhart, David L.	190	St. Louis
Gimovsky, Martin L.	002	St. Louis
Gimpelson, Richard J.	190	Chesterfield
Goeking, C. Keith	030	St. Joseph
Goldman, Gordon M.	190	St. Louis
Grant, Kenneth E.	190	St. Louis
Grant, Laura L.	026	Columbia
Grant, William M.	026	Columbia
Grechus, John J.	138	Farmington
Green, Thomas F.	125	Independence
Griffin, William T.	026	Columbia
Grimm, Mary T.	190	Chesterfield
Gulick, C. Richard	190	St. Louis
Gutknecht, Richard	125	Independence
Hahn, Yoram	190	Florissant
Halberstadt, Cathanie W.	125	Kansas City
Handler, Michael R.	190	St. Louis
Hanley, Thomas P.	190	St. Louis
Hartman, Richard A.	190	St. Louis
Hauser, Robert J.	058	Jefferson City
Hawley-Bowland, Carla G.	135	Ft. Leonard Wood
Hayes, Kimberly W.	125	Lee's Summit
Hazan, Joseph	190	Bridgeton
Heilman, M. Kathlyne	066	Bolivar
Heller, Randall L., Jr.	190	St. Louis
Hickey, James L.	190	St. Louis
Higginbotham, Dennis G.	206	West Plains
Hill, Randy C.	082	Springfield
Hoja, John M.	034	Poplar Bluff
Houck, William E.	190	Chesterfield
Hubbell, George P.	120	Osage Beach
Hulbert, Laura R.	190	St. Louis
Huse, William J., II	125	Kansas City
Huster, Robert M.	135	Liberty
Ishida, Yasuo	190	St. Louis
Jantsch, Deborah A.	125	Kansas City
Jessup, Michael J.	042	Cape Girardeau
Johar, Ravi S.	190	Bridgeton
Johnson, Joseph C., Jr.	082	Springfield
Jones, Jeffrey T.	102	Joplin
Jones, Kevin A.	026	Columbia
Jones, Michael D.	014	Mexico
Keisler, Lydia W.	058	Jefferson City
Kelly, John B.	102	Joplin
Kline, James	030	St. Joseph
Korba, Christine K.	207	Washington
Kratz, Donald P.	082	Springfield
Kuebel, Richard J.	190	St. Louis
Kumari, Vijaya	190	St. Louis

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*Doctor of Osteopathy

Lacey, Hugh L.	102	Joplin
Lamping, J. Daniels	190	Chesterfield
Lehnert, Darren L.	082	Springfield
Lemberger, Michelle R.	125	Independence
Levy, Edward S.	002	St. Louis
Lieberman, Scott A.	002	Bridgeton
Lin, C. H.	046	Moberly
Lintecum, Frederick B.	125	Kansas City
Madduri, Aruna D.	034	Poplar Bluff
***Madsen, Dana M.**	058	Jefferson City
Magaletta, George E.	002	St. Louis
Maitz, Carlos A.	190	St. Ann
Mani, Mary E.	190	St. Louis
Marshall, William H.	058	Jefferson City
Martin, Daniel J., Sr.	190	St. Louis
Matile, Gerald U.	125	Kansas City
Maupin, Kathy C.	190	Florissant
Maxson, Katherine A.	190	Chesterfield
Maynard, Colleen M.	125	Kansas City
McCorcle, Marcus D.	082	Springfield
McDavid, Robert E.	026	Columbia
McKeown, Robert A.	206	Kansas City
McLaughlin, Richard D.	082	Springfield
Medler, John F.	190	Chesterfield
Middleton, Jerry N.	190	Chesterfield
Miller, Gerald L., Jr.	125	Kansas City
Mistry, Tehmton S.	190	Columbia, IL
Moeller, F. Delbert	189	Lake St. Louis
Monterubio, Fred R., Jr.	190	St. Louis
Mooney-Smith, Patricia	125	Kansas City
Moreton, David W.	026	Columbia
Morley, Mary A.	190	Chesterfield
Muckerman, Richard C., II	190	St. Louis
Mueller, Cynthia J.	190	St. Louis
Murdock, Nathaniel	190	St. Louis
Nagy, Rickey E.	125	Kansas City
Newport, Gerald	190	Florissant
Nickell, Margaret B.	125	Kansas City
Nouri, Hassan	190	St. Louis
Oberkrom, David W.	178	Sedalia
Ohlhausen, Ward W.	050	Liberty
Ojascastro, Lou	190	St. Louis
Ong, Ofelia S.	190	St. Louis
Ostapowicz, Tamara L.	190	St. Louis
Ott, Harold J., II	190	St. Louis
Ott, William J.	190	St. Louis
Otto, William J.	082	Springfield
Padilla, Teresita C.	190	Chesterfield
Patty, Carl F.	034	Poplar Bluff
***Patty, John R.**	034	Poplar Bluff
Paul, Michael J.	190	St. Louis
Pearce, Eugene W. J.	125	Kansas City
Pearman, Carl C.	002	Kansas City
Pearse, Carlton S.	190	Chesterfield
Pearson, William E.	190	St. Louis
Perryman, Douglas R.	125	Kansas City
Phillips, Granville J.	110	Warrensburg
Philpott, Timothy C.	190	St. Louis
Poole, Anthony G.	202	Sikeston
Potts, Gregory A.	207	Washington
Pringle, Scot G.	042	Cape Girardeau
Puckett, Lynn M.	026	Columbia
Pyeatte, Jacob P., Jr.	042	Cape Girardeau
Radley, Anne M.	190	Florissant
Ratts, Valerie S.	002	St. Louis
Reynolds, Richard R.	125	Kansas City
Rice, Lee Roy	102	Joplin
Richardson, Curtis J.	030	St. Joseph
Roberts, Christopher H.	102	Joplin
Robinson, Gary L.	082	Springfield
Rosenquist, Chris R.	042	Cape Girardeau
Sachar, Jerome D.	190	St. Louis
Saha, Sudha R.	190	St. Louis
***Saleh, George A.**	050	Kansas City
Schaberg, Kevin B.	190	Chesterfield
Schuetz, Evelyne G.	189	St. Charles
Schwartz, Howard I.	125	Kansas City
Shaner, Thomas P.	190	St. Louis
Shroff, Kumkum	190	St. Louis
Shultz, Thomas M.	082	Springfield
Siripipat, Pallop	014	Mexico
Smiley, William L.	190	St. Louis
Smith, Brenda S.	125	Kansas City
Snowden, Kent L.	190	St. Louis
Sopuch, John A.	190	St. Louis
Stamps, Gregory S.	082	Springfield
Streiff, Maria G.	190	St. Louis
Strobach, Kurt F.	190	St. Louis
Stuppy, Mark S.	082	Springfield
Su, Philo S.	058	Jefferson City
Tackitt, Bobby O., II	034	Poplar Bluff
Tegeler, Kent E.	050	Liberty
Tendai, Mark M.	082	Springfield
Thomas, Jonathan L.	042	Cape Girardeau
Thompson, M. Bryant	190	Chesterfield
Thornton, Michael K.	106	St. Peters
Ting, Matthew H.	082	Springfield
Tobey, Albro C., Jr.	190	St. Louis
Tobler, Randall W.	190	St. Louis
Trammell, Lee W.	026	Columbia
Triplett, Daniel A.	050	Liberty
Trumbower, William D.	026	Columbia
Turano, William L.	125	Raytown
Tygett, Jos N.	042	Cape Girardeau
Van Dyke, Elmer H.	178	Sedalia
Villamar, Elizabeth N.	190	St. Louis
Wagner, Daniel G.	190	Chesterfield
Walker, Gary K.	082	Springfield
Walker, J. Leslie	190	St. Louis
Wallace, Darryl L.	125	Kansas City
Walley, Lynn J.	150	Hannibal
Walsh, Barbara A.	190	St. Louis
Wasserman, Mark S.	190	St. Louis
Weinstein, David L.	190	St. Louis
Werner, Caroline A.	190	Florissant
Wheeler, Paul D.	050	Liberty
White, Eugene F.	135	Rolla
Whitten, J. Stephen	042	Cape Girardeau
Wilbois, Ronald P.	190	St. Louis
Williams, Fred	026	Columbia
Williams, John W., IV	002	Springfield
Wolaniuk, Anna C.	190	St. Charles
Womack, Stephanie E.	026	Columbia
Wright, Andy J.	082	Springfield
Yahnke, David G.	138	Farmington
Yang, John S.	174	Ste. Genevieve
Yeast, John D.	125	Kansas City
Yoon, Jin S.	078	Chillicothe

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Occupational Medicine (OM)

Baker, John H.	190	St. Louis
Beeks, John W.	125	Kansas City
Belz, Norbert T.	082	Nixa
Black, William R.	102	Neosho
***Bynum, Carl G.**	058	Jefferson City
***Cooper, Glen E.**	026	Columbia
Cova, Reno R.	042	Advance
Covert, Richard A.	190	St. Louis
***Fortune, Gary J.**	002	Marthasville
Kagan, Stuart M.	125	Kansas City
Kopp, Shelby K.	190	St. Louis
Meadows, C. Douglas	190	St. Louis
Patel, Ashokkumar B.	190	St. Louis
Vale, Janie R.	026	Columbia

Oncology (ON)

Bloss, Jeffrey D.	026	Columbia
Carolla, Robert L.	082	Springfield
Croy, David W.	102	Joplin
Cunningham, William F.	082	Springfield
Eckardt, John R.	002	St. Louis
Fleming, Allan R.	125	Kansas City
Hanson, Karl H.	125	Kansas City
Honeycutt, Pamela J.	026	Columbia
Hoos, Gary L.	082	Springfield
Janney, Stephen K.	190	St. Louis
Khojasteh, Ali	026	Columbia
LaFrancis, Irving E.	102	Joplin
Luedke, Susan L.	190	St. Louis
Morris, R. William	190	St. Louis
Ota, David M.	026	Columbia
Perry, Michael C.	026	Columbia
Picus, Joel	002	St. Louis
Schlossman, David M.	026	Columbia
Schultz, Paul K.	190	St. Louis
Sheehan, Maureen H.	125	Overland Park, KS
Skelley, Mark J.	102	Joplin
Stephenson, William T.	125	Kansas City
***Stillie, G. Donald**	125	Kansas City
VanAmburg, Albert L., III	190	Chesterfield
Waheed, Shahid	014	Mexico

Ophthalmology (OPH)

Altenbernd, Todd W.	042	Cape Girardeau
Amin, Navin J.	190	St. Louis
Avins, Laurence R.	190	St. Louis
Bauman, Alan E.	125	Kansas City
Becker, Bernard	190	St. Louis
Becker, Stanley C.	190	St. Louis
Becker, William L.	190	St. Louis
Benedett, Robert E.	082	Springfield
Berdy, Gregg J.	190	St. Louis
Blair, Jerry R.	026	Columbia
Blatt, Andrew	190	St. Louis
Bohigian, George M.	190	St. Louis
Bonham, Roger D.	026	Columbia
Boniuk, Isaac	190	St. Louis
Bowen, Stephen F., Jr.	190	St. Louis
Brady, Harry R.	190	St. Louis
Brigham, David W.	190	Ballwin
Bruce, Leo A.	202	Sikeston
Burgess, Dean	190	St. Louis
Byars, Steven R.	125	Kansas City
Case, William F.	125	Kansas City
Chang, Caroline M.	002	Kansas City
Chipongian, Raul A.	190	St. Louis
Chishti, M. Ishaq	190	St. Louis
Chu, Fred C.	190	Chesterfield
Clever, Victor G.	189	St. Charles
Cokingtin, Cliff	125	Overland Park, KS
Cowden, John W.	026	Columbia
Cozean, Charles H.	042	Cape Girardeau
***Crane, William G.**	030	St. Joseph
Deligeorges, John	002	Kansas City
Doane, John F.	125	Independence
Durrie, Daniel S.	125	Kansas City
Dyer, David S.	125	Kansas City
Eggleston, Harry C.	190	St. Louis
Ellis, Jean H.	125	Prairie Village, KS
Escoffery, Richard F.	190	Florissant
Essman, Thomas F.	082	Springfield
Faulkner, C. Byron	082	Springfield
Fitz, John R.	138	Farmington
Ford, Thomas E.	190	Niagara Falls, NY
Gabel, Michael G.	190	St. Louis
Gans, Lawrence A.	190	Florissant
Gessler, James A.	082	Springfield
Goldstein, Marvin F.	125	Kansas City
Goltschman, John P.	190	Florissant
Gramates, Peggy H.	190	Florissant
Grand, M. Gilbert	190	St. Louis
Green, Morton R.	190	Belleville, IL
Hagan, John C., III	050	N. Kansas City
Hart, William M., Jr.	190	St. Louis
Hembree, Kathryn A.	050	Liberty
Hinshaw, Kevin D.	190	St. Louis
Holds, John B.	190	St. Louis
Holekamp, Timothy	026	Columbia
Hunkeler, John D.	125	Kansas City
***Jordan, Earl L., Jr.**	102	Joplin
Joseph, Daniel P.	002	St. Louis
Jung, J. Marshall	042	Cape Girardeau
Kamenetzky, Stephen A.	190	St. Louis
Kaplan, Henry J.	190	St. Louis
Kapp, Marybeth	042	Cape Girardeau
Kass, Michael A.	190	St. Louis
Kayes, Jack	190	St. Louis
Keithahn, Mari A.Z.	026	Columbia
Kenneally, Cynthia Z.	190	St. Louis
Khatana, Anup K.	125	Prairie Village, KS
Kies, Richard L.	042	Cape Girardeau
Knopf, Harry L.	190	St. Louis
Kolker, Allan E.	190	St. Louis
Korenfeld, Michael S.	207	Washington
Kretchmar, Alan P.	190	St. Louis
Krummenacher, Thomas K.	190	St. Louis
Lederer, Charles M., Jr.	125	Kansas City
Lee, King Y.	125	Shawnee Mission, KS
Lee, Steven F.	002	St. Louis
Leibsohn, Joel M.	125	Independence
Lentz, Kathy J.	207	Washington
Levy, Donald S.	189	St. Charles
Lewin, W. Howard	190	St. Louis
Lewis, Matthew T.	058	Jefferson City
Lewis, Robert D.	190	St. Louis
Lubniewski, Anthony J.	190	St. Louis
Luetkemeyer, James G.	058	Jefferson City

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***Lumsden, Todd J.**	042	Cape Girardeau
Lyon, David B.	125	Prairie Village, KS
Matta, Camille S.	125	Kansas City
Mattax, James B., Jr.	082	Springfield
McKnight, Scott J.	050	Liberty
Mehlhorn, Gary L.	082	Springfield
Michaels, Robert H.	082	Springfield
Milder, Barry D.	190	St. Louis
Morey, Kirk P.	190	St. Louis
Morgan, Stephan S.	190	St. Louis
Morrison, Tom V.	208	Branson
Murphy, James A.	030	St. Joseph
Neu, Kenneth W.	082	Springfield
Neu, Leo T., III	082	Springfield
O'Donnell, Francis E.	190	St. Louis
Ott, F. Thomas	190	St. Louis
Parker, Derrall A.	042	Cape Girardeau
Perlmutter, John C.	189	St. Charles
Pernoud, Flavius G., III	190	St. Louis
Pernoud, Joan M.	190	St. Louis
Peterson, Craig A.	082	Springfield
Piebenga, Larry W.	125	Kansas City
Pojanasomboon, Pichat	135	Rolla
Poulose, Abraham K.	125	Prairie Village, KS
Prater, Thomas G.	082	Springfield
Price, Patrick K.	125	Shawnee Mission, KS
Purcell, John J., Jr.	190	St. Louis
Rahman, Moudur	190	Chesterfield
Reddy, Nalini A.	206	West Plains
Rednam, Krishnarao V.	190	St. Louis
Ridgeway, William G.	190	St. Louis
Rieger, Frank G.	026	Columbia
Ringer, C. Nelson	042	Cape Girardeau
Rogers, Casey	014	Mexico
Rosenthal, William N.	125	Kansas City
Sabates, Felix N., Sr.	125	Prairie Village, KS
Sabates, Nelson R.	125	Prairie Village, KS
Sabates, Roland	125	Kansas City
Samudrala, Ramulu	190	St. Louis
Saxe, Stephen J.	042	Cape Girardeau
Schoengarth, Lowell D.	026	Columbia
Schrenk, Loren C.	190	St. Louis
Scott, Wendell J.	082	Springfield
Shah, Ramesh R.	102	Joplin
Shelton, R. Wayne	082	Springfield
Short, Howard N.	207	Washington
Sigmund, Charles A.	190	Bridgeton
Silverstein, Steven M.	125	Kansas City
Slocum, Stephen G.	190	St. Louis
Smith, Porter	070	Poplar Bluff
Spalding, Wilber B., Jr.	125	Kansas City
Spurrier, Mark H.	190	St. Louis
Stafford, Walter R.	190	St. Louis
Stewart, L. Paul	190	St. Louis
Stiles, Michael C.	125	Kansas City
Stout, Carl N.	125	Independence
Tauber, Joseph	125	Prairie Village, KS
Taylor, John R.W.	125	Independence
Tekwani, Hiralal T.	190	St. Louis
Tess, Allen F.	190	Florissant
Thomas, Matthew A.	190	St. Louis
Tobin, Robert F.	030	St. Joseph
Unterman, Steven R.	125	Kansas City
Unwin, Donald R.	190	St. Louis
Walline, T. Andrew	125	Prairie Village, KS
Wankum, Robert P.	058	Jefferson City
Watson, R. Alan	030	St. Joseph
Wax, Martin B.	190	St. Louis
Weir, Robert K.	125	Kansas City
Westrich, David J.	042	Cape Girardeau
Wexler, Stephen A.	190	St. Louis
White, William L.	125	Kansas City
Wieder, Richard H.	190	St. Louis
Wills, Theodore E.	026	Columbia
Wurster, Jerry B.	125	Prairie Village, KS
Yang, H. Kell	026	Columbia
Ziemianski, Matthew C.	125	Kansas City

Orthopedic Surgery (ORS)

Abernathie, Dennis L.	026	Columbia
Albus, Thomas E.	190	Bridgeton
Allen, William Corwin	026	Columbia
Anderson, David J.	190	St. Louis
Anglen, Jeffrey O.	026	Columbia
Aubuchon, Craig E.	190	St. Louis
Baldwin, Richard, Jr.	190	St. Louis
Ball, David A.	102	Joplin
Bassman, Donald R.	190	St. Louis
Beall, McPherson S., Jr.	125	Kansas City
Beckett, Wm. Wilson	026	Columbia
Belew, Mark	190	Florissant
Bernhardt, Mark	125	Kansas City
Bieniek, Christopher M.	150	Hannibal
Black, David L.	102	Joplin
Blair, Vilray P., III	190	St. Louis
Bliss, Greg A.	125	Blue Springs
Bohn, William W.	125	Kansas City
Bonar, Susan K.	125	Kansas City
Boylan, Peter C.	125	Kansas City
Bradbury, George R., III	190	Bridgeton
Bruce, Robert P.	125	Kansas City
Buchert, Peter K.	026	Columbia
Burke, James S., Jr.	190	St. Louis
Burleigh, Bruce W.	102	Joplin
Burns, Michael F.	190	St. Louis
Burton, Curtis D.	150	Hannibal
***Cameron, Roger W.**	058	Jefferson City
Chalk, David E.	207	Washington
Cho, Kyu S.	190	St. Louis
Clarke, Michael S.	082	Springfield
Clothiaux, Pierre L.	082	Springfield
Collins, John W., Jr.	125	Independence
Cordell, Larry D.	125	Kansas City
Couchman, Ryan W.	190	St. Louis
Cunningham, R. Raymond	026	Columbia
Curnow, Richard B.	050	Liberty
Darnell, Dale E.	125	Kansas City
Davis, Leonard L.	014	Columbia
Davis, Richard V.	150	Hannibal
Deweese, Frederick T.	190	St. Louis
DiFilippo, Emil A.	189	St. Charles
Downs, Daniel M.	125	Kansas City
Drisko, Robert M., II	125	Kansas City
Dubin, Sol H.	125	Independence
Dugan, Gerald F.	125	Kansas City
Duncan, Douglas M.	082	Springfield
Eckenrode, James F.	026	Columbia

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***Ellefsen, Brian K.**	Carthage	102
Eller, Gordon W.	Cape Girardeau	042
Ellfeldt, Howard J.	Kansas City	125
Emanuel, James P.	St. Louis	190
Esch, John G.	Joplin	102
Evans, Lawrence G., Jr.	St. Louis	190
***Farley, Gary W.**	St. Louis	190
Fox, Thomas J.	St. Louis	190
Frank, Gael R.	N. Kansas City	125
Frevert, Larry F.	Kansas City	125
Frumson, Guy H.	Florissant	190
Gaines, Robert W.	Columbia	026
Gainor, Barry J.	Columbia	026
Galakatos, Gregory R.	St. Louis	190
***Galbraith, Timothy C.**	Jefferson City	058
Glaser, Larry F.	Cleveland	125
Gondring, William H.	St. Joseph	030
***Graven, Timothy G.**	St. Charles	189
Greene, Walter B.	Columbia	026
Grillot, Michael B.	Springfield	082
Gurba, Danny M.	Kansas City	125
Haas, Robert W.	Liberty	050
Hagan, Phillip F.	Liberty	050
Hammond, D. Wade	St. Louis	190
Harmon, Ben C.	Springfield	082
Harris, Hugh G.	Springfield	082
Harris, Lanny W.	Kansas City	125
Haupt, Herbert A.	St. Louis	190
Havey, John	Columbia	026
Healy, Brian E.	Kansas City	125
Highland, Thomas R.	Columbia	026
Holand, Roy W.	Springfield	082
Hollocher, Richard J.	St. Louis	190
Hummel, Gregory L.	Independence	125
Humphreys, William	St. Joseph	030
***Hunter, Harlen C.**	Chesterfield	190
Jarka, Dale E.	Kansas City	125
Jeffries, Joel T.	Columbia	026
Johnson, Glen E.	St. Louis	190
Johnston, Richard	St. Louis	190
Jolly, Ben L.	Mexico	014
Jones, Bruce N.	Chesterfield	190
Jones, Robert P.	Blue Springs	125
Kapp, William K., III	Cape Girardeau	042
Kefalas, John C.	Washington	207
Kenney, John D.	St. Louis	002
Kenter, Keith	Columbia	026
Keohane, Mark	St. Charles	189
Kiburz, Douglas W.	Sedalia	178
Koch, F. Daniel	Kansas City	125
Kramer, Robert S.	St. Louis	190
Krautmann, John J.	Jefferson City	058
Kriegshauser, Lawrence A.	St. Louis	190
Lander, Robert C.	St. Louis	190
Lange, David R.	Bridgeton	190
Lee, Thomas K.	St. Louis	190
Lehman, Richard C.	St. Louis	190
Lents, Rickey L.	Cape Girardeau	042
Leslie, James T.	Jefferson City	058
Lieurance, Robert K.	Joplin	102
Linsenmeyer, Charles M.	St. Charles	189
Littlejohn, Robert T.	N. Kansas City	050
Lord, Richard E.	St. Louis	190
Luechtefeld, Frank	Florissant	190
Luther, George A.	St. Louis	190
Mannis, Charles I.	St. Louis	190
Manske, Paul R.	St. Louis	190
Marshall, Michael P.	Kansas City	002
Marti, Larry B.	Rolla	135
Martin, Daniel J., Jr.	St. Louis	190
Martin, Jeffrey W.	St. Louis	190
Matthews, Thomas D.	Washington	207
Maylack, Fallon H.	Florissant	190
McClain, Thomas D.	Springfield	082
McCormack, Thomas J.	Independence	125
McMullin, Forbes A.	St. Louis	190
McMurray, Scott W.	Springfield	082
McNamara, Gerald R.	Kansas City	125
McQueary, Frederick G.	Springfield	082
Medler, Robert G.	St. Louis	190
Mell, Roger L.	Chesterfield	190
Merenda, Frank J.	St. Louis	190
Merenda, James T.	St. Louis	190
Miller, Harry G.	Clinton	086
Mirbaha, Mitchell M.	St. Louis	190
Mirkin, Rhoderic P.	St. Louis	002
Moretz, J. Alfred III	Cape Girardeau	042
Morris, Alan H.	St. Louis	190
Nachtigal, Michael P.	Springfield	082
Neighbor, Ernest H.	Kansas City	125
Newland, Craig C.	Liberty	050
Nogalski, Michael P.	St. Louis	190
Olive, Paul M.	Springfield	082
Otis, Stephanie A.	Town & Country	190
***Page, Lawrence V.**	Joplin	102
Parkins, George K.	Kansas City	125
Parsons, Clyde W., III	Springfield	082
Pawsat, John E.	Kansas City	125
Pearson, Richard L.	Ste. Genevieve	174
Petkovich, Frank O.	St. Louis	190
Phillips, John J.	Florissant	190
Phillips, Thomas P.	Kansas City	125
Piontek, Jerome G.	Chesterfield	190
Putnam, John L.	Springfield	082
Reardon, James P.	N. Kansas City	050
Rhoades, Charles E.	Kansas City	125
Rich, Margaret M.	St. Louis	190
Rispler, David T.	Jefferson City	058
Ritter, Ray A., Jr.	Cape Girardeau	042
Rodgers, W. Blake	Jefferson City	058
Rosenthal, Howard G.	Kansas City	125
Roush, Randall D.	Florissant	190
***Rummel, Theodore S.**	Wentzville	002
Samson, Barry L.	St. Louis	190
Samuelson, Thomas S.	Kansas City	125
Sandow, Theodore	Kansas City	125
Satterlee, C. Craig	Kansas City	125
Schaberg, James E.	St. Charles	189
Schlafly, Bruce S.	St. Louis	190
Schlafly, Edward F., Jr.	Chesterfield	190
Schmidt, Thomas L.	Kansas City	125
Schoedinger, George R., III	St. Louis	190
Schoenecker, Perry L.	St. Louis	190
Schroer, William C.	Bridgeton	190
Schwarze, Daniel J.	St. Louis	190
Sciortino, Robert A.	Bridgeton	190
Seagrave, Richard A.	Springfield	082
Sedgwick, William G.	St. Louis	190

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Sertl, George O. St. Louis	190
Shaeffer, James T. Springfield	082
Sheridan, John J. St. Louis	190
Shitut, Ravindra V. St. Louis	190
Sicat, Alfonso V. Warrensburg	110
Smith, Bruce D. St. Joseph	030
***Smith, C. Daniel** St. Joseph	030
Smith, Kenneth R. Bolivar	206
Smith, Patrick A. Columbia	026
Stokes, Douglas L. St. Joseph	030
Strickland, James C. St. Louis	190
***Stringer, Robert F.** Joplin	102
Strong, Alexandra J. Kansas City	125
Stronsky, David St. Louis	190
Sudekum, Joseph M. St. Louis	190
Susi, Jesse G. St. Louis	190
Swaim, Truett Kansas City	125
Swango, J. Scott Springfield	082
Takacs, Robert J. Kansas City	125
Tessier, John E. St. Louis	190
Thomas, Leslie D. N. Kansas City	050
Thorpe, William P. Cape Girardeau	042
Tillema, David A. Kansas City	125
True, John H. Poplar Bluff	034
Trueblood, Michael C. Cape Girardeau	042
Tucker, Robert E. St. Louis	190
Tupper, Joel Joplin	102
Turnbaugh, Thomas R. Jefferson City	058
Turner, Michael L. Poplar Bluff	034
Van Ryn, Jacques S. Bridgeton	190
Veitch, John M. Joplin	102
Vierling, Stephen E. St. Louis	190
Vilmer, Stephen E. N. Kansas City	050
Wagner, John R. St. Louis	190
Wakeman, Newt, Jr. Springfield	082
Wayne, Sherwyn J. St. Louis	190
Weise, Marc W. Santa Maria, CA	190
Weltmer, John B., Jr. St. Louis	190
West, Harold D. Independence	125
Whitaker, James H. Kansas City	125
Whiteside, Leo A. St. Louis	190
Williams, Joseph St. Louis	190
Zehnder, Kenneth W. St. Louis	190

Otolaryngology (OTO)

Ailor, Edgar I. Columbia	026
Allphin, Allan L. Springfield	082
Bailey, Sean B. St. Louis	190
Benecke, James E., Jr. St. Louis	190
Berkowitz, Wallace P. St. Louis	190
Beuerlein, Matthew E. Kansas City	002
Bonacorsi, John Bridgeton	190
Boone, Karen E. St. Charles	189
Boyd, James H. St. Louis	190
Branham, Gregory H. St. Louis	190
Brown, Rebecca L. Springfield	082
Burroughs, Nathan D. N. Kansas City	050
Christiansen, Sidney G. St. Joseph	030
Citardi, Martin J. St. Louis	002
***Coffman, Avon C.** Kansas City	125
Cook, Paul R. Columbia	026
Coonce, D. Curtis Cape Girardeau	042
Cotton, Thomas R. Shawnee, KS	125
Craig, Robert D. St. Louis	002
Dahm, John D. St. Louis	190
Davis, Sheldon Florissant	190
Davis, William E. Columbia	026
Denninghoff, James S. Columbia	026
Devine, Mark W. N. Kansas City	050
Druck, Norman S. Chesterfield	190
Ehrlich, Carl F. St. Louis	190
Eisenbeis, John F. St. Louis	190
Ellis, John C. Independence	125
Eyen, Thomas P. Overland Park, KS	125
Forsen, James W., Jr. St. Louis	190
Friedman, William H. St. Louis	190
Goebel, Joel A. St. Louis	190
Guastello, Joseph R. Kansas City	125
Guastello, Mario J. Kansas City	125
Hahn, Frederick W. Independence	125
Ham, Kevin R. Poplar Bluff	034
Hantz, Oscar Florissant	190
Hartman, James M. St. Louis	190
***Hechler, Mark L.** Warrensburg	110
Herzog, Jacques A. Chesterfield	190
Hill, David K. N. Kansas City	125
Ingram, Donald R. Festus	190
Ippensen, John H. Springfield	082
Jung, Christopher H. Cape Girardeau	042
Katsantonis, George St. Louis	190
Kirsch, Jeffrey P. St. Louis	190
Kletzker, G. Robert St. Louis	190
Knudson, Dennis R. Columbia	026
Krenning, Judyann Rolla	135
Kroeger, George B., Jr. St. Louis	190
Lampros, William P. St. Louis	190
Levine, Laurence A. St. Charles	190
Lima, Jose A. St. Louis	190
Loynd, Robert C. St. Louis	002
Luetje, Charles M. Kansas City	125
Mangum, William B. Independence	125
Marchiando, Albert W. Washington	207
Martin, Richard A. Cape Girardeau	042
Marty, David R. Jefferson City	058
Maslan, Mark J. Overland Park, KS	125
McGonigle, Michael M. Joplin	102
McKinney, John W. St. Louis	190
Moritz, Gerald Bridgeton	190
Neely, J. Gail St. Louis	190
Pavlovich, Andrew S. Independence	125
Piccirillo, Jay F. St. Louis	190
Price, Richard B. Overland Park, KS	125
Reichert, Timothy J. St. Louis	190
Renner, Gregory J. Columbia	026
Sargent, Eric W. St. Louis	002
Schroeder, Walter A., Jr. Cape Girardeau	042
Sessions, Donald G. St. Louis	190
Shagets, Frank W. Joplin	102
Shah, Bharat Springfield	082
Sherman, David M. Springfield	082
Singleton, Marvin A. Joplin	102
Smith, Courtland P., Jr. Kennett	070
Smith, Peter G. St. Louis	190
Snow, Jon F. Springfield	082
Spector, Gershon St. Louis	190
Stith, John A. St. Louis	190
Templer, Jerry W. Columbia	026
Thawley, Stanley E. St. Louis	190

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Thedinger, Bradley S.	125	Kansas City
Viers, Wayne A.	190	St. Louis
Walls, Kelvin	125	Independence
Waxman, Joel E.	082	Springfield
Wible, Jerry C.	082	Springfield
Wild, Alan P. K.	190	Chesterfield
Willman, Martin L.	189	St. Charles
Wolfe, James B.	082	Springfield
Yates, Karen	042	Cape Girardeau
Zitsch, Robert P., III	026	Columbia
Zujko, Richard D.	135	Rolla

Pathology (PTH)

Alexander, Susie	002	Lawrence, KS
Arthur, Gerald L.	026	Columbia
Bari, Wagih A.	190	St. Louis
Benson, Russell L.	125	Kansas City
Breckenridge, Robert L.	050	Kansas City
Callaway, Lawrence A.	125	Kansas City
Carlson, John V.	014	Mexico
Case, Mary E.	190	St. Louis
Caughron, Michael R.	125	Kansas City
Cento, Donald P.	202	Sikeston
Costin, Jimmy L.	034	Poplar Bluff
Craver, Jeffrey L.	190	St. Louis
Cummings, Kenneth C.	125	Kansas City
Curry, Michael D.	026	Columbia
Darkow, Grant V.	026	Columbia
Dehner, Louis P.	190	St. Louis
DeFeo, Theodore C.	125	Kansas City
Dorzab, William E.	125	Raytown
Dumadag, Virgilio P.	190	St. Louis
Evans, Maria L.	026	Columbia
Ferris, Charles W., Jr.	190	St. Louis
Fritzlen, Thomas J.	125	Overland Park, KS
Galblum, Larry I.	125	Kansas City
Gauthier, Charles P.	125	Kansas City
Hall, Stanley G.	150	Hannibal
Hamel, Peter C.	150	Hannibal
Henry, Lawrence D.	058	Columbia
Henry, Mary M.	125	Kansas City
Hopson, David K.	190	St. Charles
Horn, Paul C.	042	Cape Girardeau
Hosler, Mark W.	042	Cape Girardeau
Hurly, Michael P.	102	Joplin
Janssen, Margaret E.	102	Joplin
Johnson, Dennis L.	178	Sedalia
Johnson, Gareth R.	125	Kansas City
Johnson, Gordon L.	106	Crystal City
Johnson, Steven M.	190	St. Louis
Jones, Randall W.	125	Independence
Kane, Michael J.	034	Poplar Bluff
Kang, Juan	190	St. Louis
Keiper, Arthur S., III	026	Columbia
Kerley, Spencer W.	125	Overland Park, KS
King, Gregory S.	190	St. Louis
Kissane, John M.	190	St. Louis
Kleopfer, Lynn L.	026	Columbia
Kraus, Frederick T.	190	St. Louis
Landgraf, James R.	125	Independence
LaBach, James P.	125	Overland Park, KS
Levy, Beth K.	190	St. Louis
Litton, Nancy J.	125	Blue Springs
Lombardo, Joseph A.	190	St. Louis
Marshall, Hal E.	125	Overland Park, KS
Martin, Scott A.	190	St. Louis
McIntire, Timothy L.	058	Jefferson City
Millett, Ruth E.	125	Kansas City
Mockli, Gary C.	190	St. Louis
Morrison, R. Gideon	206	West Plains
Munoz, Phillip A.	125	Kansas City
Ost, Mark D.	125	Kansas City
Paez, Mauro A.	190	St. Louis
Peterson, Ila M.	125	Leawood, KS
Pittman, Gerald R.	190	St. Louis
Poger, Marshall E.	190	St. Louis
Prey, Marianne U.	190	St. Louis
Ramos, Ricardo R.	190	Jacksonville, FL
Rao, Sumati	190	St. Louis
Rawson, Perry G.	207	Washington
Rollo, John L.	190	St. Louis
Rudloff, Mary A.	002	St. Louis
Salvador, Antonio	190	St. Louis
Seitz, Elson F.	125	Independence
Shelley, James M.	082	Springfield
Short, Charles D.	190	St. Louis
Siegel, Carl D.	125	Kansas City
Silliman, York E.	030	St. Joseph
Spollen, Linda E.	026	Columbia
Stahr, William D.	042	Cape Girardeau
Sueper, Robert H.	190	St. Louis
Tritz, Denise M.	058	Jefferson City
Turgeon, Ronald P.	190	St. Louis
Vergara, Gerardo G.	125	Kansas City
Villanueva, Angela A.	125	Overland Park, KS
Vo, Thuy-Lieu T.	190	St. Louis
Wachter, Ronald M.	082	Springfield
Young, Thomas W.	125	Kansas City

Pediatrics (PD)

Adams, Susan E.	190	St. Louis
Allen, Jerry H.	207	Washington
Altemeier, William A., III	026	Columbia
Amjad, Mohammad T.	190	St. Louis
Andrews, Elizabeth J.	082	Springfield
Ayyagari, Sujatha R.	138	Potosi
Baker, Kristie A. R.	125	Overland Park, KS
Baker, Marion H.	058	Jefferson City
Belen, Marietta	106	Festus
Benoist, Walter F.	190	Bridgeton
Birmingham, Jean E.	190	St. Louis
Bordy, Marvin D.	125	Kansas City
Bouhasin, John D.	190	St. Louis
Bowers, James E.	190	Kirkwood
Braddock, Stephen	026	Columbia
Britton, Loretta M.	125	Kansas City
Bunge, Nancy J.	014	Mexico
Burgdorf, Max H.	190	Bridgeton
Burry, Virgil F.	125	Blue Springs
Bussmann, Yvonne L.	082	Springfield
Cano-DeBelen, Grace	150	Canton
Cantor, Harvey E.	190	St. Louis
Casey, Eliot C.	190	St. Louis
Clary, Randall A.	002	St. Louis
Clothier, Robert W.	002	Independence
Cockerell, Charles F.	125	Blue Springs
Cokingtin, Diana L.	125	Kansas City
Conger, Susan C.	190	St. Louis
Conley, Brian S.	058	Jefferson City
Cook, Katherine S.	135	Rolla
Dempsey, Maureen E.	026	Columbia

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DeCastro, Fernando J.	138	Pilot Knob
DeSilva, Ananda	190	Hazelwood
Diehl, Elizabeth W.	190	St. Louis
Diemer, Jean	042	Cape Girardeau
Dinkins, James A.	042	Cape Girardeau
Eschmann, Diane M.	190	St. Louis
Farberman, Elliott	190	Florissant
Floyd, Marla J.	082	Springfield
Flug, Eric J.	190	St. Louis
Forgue, Donald R.	002	Kansas City
Friedman, Ira J.	207	Washington
Fusselman, Jon M.	082	Springfield
Gellman, Elliot F.	190	St. Louis
Glines, Michael H.	190	Arnold
Goldberg, Joseph P.	125	Mission, KS
Goldstein, David E.	026	Columbia
Griesemer, Bernard A.	082	Springfield
Grimes, Alan	002	N. Kansas City
Groshong, Ted D.	026	Columbia
Hall, Robert T.	125	Kansas City
Hanks, Michael S.	082	Springfield
Harris, Weldon L.	002	Independence
Harrison, Thomas J., Jr.	189	St. Charles
Harwell, J. Larry	190	St. Louis
Hennessey, Ann M.	058	Jefferson City
Herbers, Mark F.	190	Fenton
Hicks, Christina M.	038	Fulton
***Hoffman, James E.**	042	Cape Girardeau
Holmes, Nancy E.	190	St. Louis
Horan, John J., Jr.	190	St. Louis
Howard, Campbell P.	125	Kansas City
Ip, Aidan W.	190	St. Louis
Jacobson, Jill D.	125	Kansas City
James, Elizabeth J.	026	Columbia
Jones, Robert R.	214	Nevada
Kanarek, Joseph	125	Kansas City
Keefe, David M.	189	O'Fallon
Khan, Abdul G.	190	Arnold
Khurana, Satish K.	125	Lenexa, KS
Kilbride, Howard W.	125	Kansas City
Knapp, Jane F.	125	Kansas City
Knock, Henry L.	190	St. Louis
Koenig, Joel S.	190	St. Louis
Kosse, Karl E.	030	St. Joseph
Krahn, Eve M.	050	Kansas City
Kreusser, Katherine L.	190	St. Louis
Krishna, Padma	125	Shawnee Mission, KS
Kronemer, Norton S.	190	St. Louis
Limpiphiphatn, Ester P.	174	Perryville
McElroy, George L., III	058	Jefferson City
McIntosh, Michele C.	125	Independence
McNeal, Douglas M.	082	Springfield
Meyer, John W.	082	Springfield
Miles, Judith H.	026	Columbia
Mitra, Nirmal K.	125	Kansas City
Monteleone, Patricia L.	190	St. Louis
Moss, Debra L.	190	Chesterfield
Motier, Thomas H.	190	St. Louis
Mueller, Janet G.	190	St. Louis
Muraywid, Ahmad H.	014	Mexico
Murphy, Timothy P.	030	St. Joseph
Newman, William R.	102	Joplin
Nile, David A.	190	St. Louis
O'Neil, Jerome H., Jr.	190	St. Louis
Olson, Gary S.	042	Cape Girardeau
Olson, Lloyd C.	125	Kansas City
Oppermann, Karen J.	125	Independence
Peterson, Frederick D.	190	St. Louis
Phillips, Abraham M.	190	St. Louis
Pitiyanuvath, Tasanaporn	125	Kansas City
Pittman, Susan	190	St. Louis
Plax, Steven I.	190	St. Louis
Powell, Alan E.	125	Independence
Rejent, Anthony J.	190	St. Louis
Rice, Kathleen G.	082	Springfield
Richmond, Angela R.	082	Springfield
Rising, Dean R.	082	Springfield
Roberts, Charles C.	125	Kansas City
Roberts, Phyllis G.	030	St. Joseph
Ross, William J.	190	Bridgeton
Russell, Trent	120	Osage Beach
Ryser, Carol A.	125	Kansas City
Sakmar, Douglas A.	190	St. Louis
Sammon, T. James	082	Springfield
Sato, George	190	Chesterfield
Sato, Richard W.	190	Chesterfield
Scalzo, Anthony J.	190	St. Louis
Schmidt, Martin P.	190	St. Louis
Schnidman, Jacquelyn C.	190	St. Louis
Schwartz, I. David	125	Kansas City
Sharma, Vidya	125	Kansas City
Sheehan, Michael B.	125	Kansas City
Sherman, W. Gary	190	Chesterfield
Simmons, Connie D.	042	Cape Girardeau
Solanki, Nareshkumar J.	190	Lake St. Louis
Sponenberg, Don D.	082	Springfield
Sultan, Tipu	190	Florissant
Tenorio, Genoveva	158	Albany
Tillman, Mary A.	190	St. Louis
Truog, William E.	125	Kansas City
Vermont, Sharon D.	002	St. Louis
Walentik, Corinne	190	St. Louis
***Wasserman, Gary S.**	125	Kansas City
Waxelman, Roger J.	190	Ballwin
Weldon, Virginia V.	190	St. Louis
Westerfeld, Roy A.	189	St. Charles
Wheeler, Camilla A.	058	Jefferson City
Wicklund, Brian M.	125	Kansas City
Willis, Carol	046	Moberly
***Wilson, James W.**	082	Springfield
Wimmer, Warren J.	190	Florissant
Wool, Gerald	190	St. Louis
Zahn, Robert L.	082	Ozark

Pediatric Allergy (PDA)

Cannon, Richard E.	189	St. Charles
Siegel, Charles	050	Gladstone

Pediatric Cardiology (PDC)

Canent, Ramon V.	125	Kansas City
Gowdamarajan, Rengasamy	125	Kansas City
Hubbell, Marius M., Jr.	125	Kansas City

Pediatric Endocrinology (PDE)

Huseman, Carol A.	002	Overland Park, KS

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Pediatric Radiology (PDR)

Launius, Gregory D.	190	St. Louis
Wadsworth, Deborah T.	190	St. Louis

Pediatric Surgery (PDS)

Ashcraft, Keith W.	125	Overland Park, KS
Bell, Martin J.	190	St. Louis
Cradock, Thomas V.	190	St. Louis
Helikson, Mary A.	026	Columbia
Murphy, John P.	125	Overland Park, KS
Sharp, Ronald J.	125	Overland Park, KS
Snyder, Charles L.	125	Overland Park, KS

Physical Medicine & Rehabilitation (PM)

Al-Shathir, Saad	102	Joplin
Alias, Susy	190	St. Louis
*Burns, Bernard C., III	042	Cape Girardeau
Clark, Jennifer L.	026	Columbia
Conway, Robert R.	026	Columbia
Fischer, Ronald L.	190	Chesterfield
Folz, Thomas J.	058	Jefferson City
Galate, Joseph F.	125	Kansas City
Gnatz, Steven	026	Columbia
Griesemer, Julia E.	082	Springfield
Hoffarth, Sharon C.	190	St. Louis
Karges, Melvin D.	102	Joplin
Kelly, Charles R.	125	Kansas City
Knakal, Roger C.	125	Kansas City
Lytle, Edwin L.	190	St. Louis
Middleton, Mary Jo	030	St. Joseph
Page, Jennifer L.	190	St. Louis
Pratt, Terrence	125	Kansas City
Randolph, Bernard C., Jr.	002	Bridgeton
*Rupright, S. Jon	026	Columbia
Samudrala, Suseela	190	St. Louis
Wheeler, Eden	125	Kansas City
Wice, Martin B.	190	St. Louis
Winkler, Terry	082	Springfield
*Woods, Brenda L.	058	Hartsburg

Plastic Surgery (PS)

Barnthouse, Joseph R.	125	Kansas City
Bennett, Danny	125	Kansas City
Brown, David M.	190	St. Louis
Cabbabe, Edmond B.	190	St. Louis
Caplin, David A.	190	St. Louis
Coin, Richard E.	190	St. Louis
Copeland, Jeffrey G.	189	St. Peters
Corwin, Kenneth D.	190	St. Louis
Crandall, Richard E.	190	Chesterfield
Croll, Gregory H.	026	Columbia
Deisher, David M.	042	Cape Girardeau
DePriest, Michael D.	030	St. Joseph
Domann, Darrel D.	082	Springfield
Ettelson, Charles D.	190	Chesterfield
Feliciano, Wilfrido C.	190	Maryland Heights
Fortin, Don G.	050	Kansas City
Francel, Thomas J.	002	St. Louis
Garrison-Kester, Carla	082	Springfield
Geraghty, Thomas E.	125	Kansas City
German, David S.	190	St. Louis
Geter, Rodney K.	082	Springfield
Goldstein, Marcy A.	002	St. Louis
Guinn, O. Allen, III	125	Independence
Gutek, E. Philip	125	Kansas City
Hart, William G., Jr.	190	St. Louis
Hawes, Arthur S.	082	Springfield
Heimburger, Richard A.	058	Jefferson City
Higgs, Philip E.	190	St. Louis
Huffaker, William H.	190	St. Louis
Hunzicker, Kathleen A.	125	Shawnee Mission, KS
Jones, Timothy R.	190	St. Louis
Kaplan, Michael F.	026	Columbia
Kofkoff, Richard L.	190	Bridgeton
Koo, Michele D.	190	St. Louis
Lomax, John E.	208	Branson
Lund, Herluf G., Jr.	190	Chesterfield
Marsh, Jeffrey L.	190	St. Louis
McGuire, Patricia A.	190	St. Louis
Meystrik, Rosellen S.	082	Springfield
Mischnick, Carol R.	190	Chesterfield
Mossie, Raymond D.	002	Kansas City
O'Connell, Timothy	190	St. Louis
Onken, Henry D.	190	St. Louis
Payne, Meredith J.	190	St. Louis
Price, Carl I.	082	Springfield
Puckett, Charles L.	026	Columbia
Reynolds, William R.	082	Springfield
Rinehart, Gregory C.	190	St. Louis
Rodgers, Jody A.	058	Jefferson City
Rottler, Paul D.	190	St. Louis
Scheu, James H.	190	St. Peters
Seaberg, John J., III	026	Columbia
Sherrod, Duane W.	102	Joplin
Stevens, Sheridan	125	Independence
Stromberg, Brent V.	190	St. Louis
Thompson, Frederick E.	050	Liberty
Tobin, Gregory A.	042	Cape Girardeau
White, Bruce I.	190	St. Louis
Winsky, Arlen D.	082	Springfield
Woodberry, Kerri M.	190	St. Louis
Young, Robert A.	190	Chesterfield

Psychiatry (P)

Ajans, Zaki A.	014	Mexico
Aleksander, Bernardo G.	190	El Paso, TX
Allison, James B.	082	Springfield
Anderson, Thomas R.	026	Columbia
Baird, Keim L.	189	St. Charles
Bassett, Gregg E.	002	St. Louis
Batterson, James R., Jr.	125	Kansas City
Beck, David A.	026	Columbia
Beitman, Bernard D.	026	Columbia
Berland, David I.	190	St. Louis
Bock, Linda P.	190	St. Louis
Bright, James E.	082	Springfield
Brog, Michael A.	190	St. Louis
Cabanas, Justo J.	125	Shawnee Mission, KS
Calhoun, Joshua W.	190	St. Louis
Callahan, Joseph D.	190	St. Louis
Callaway, Jo J.	002	Kansas City
Choi, Sei Young	189	St. Charles
Cole, Sherman W.	125	Kansas City
Corvalan, Juan C.	190	St. Louis
Crane, John B.	207	Washington
Croughan, Jack L.	190	St. Louis
Crumpacker, Margaret	190	St. Louis

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Dewald, Paul A.	190	St. Louis
Dewein, Edward G.	190	St. Louis
Dick, M. Marga	026	Ashland
Dobard, Dennis P., Jr.	082	Springfield
Dowell, George H.	190	St. Louis
Edmisten, Jack	125	Independence
Efstathianos, Kimon	190	Belleville, IL
Eppright, Thomas D.	026	Cleveland, OH
Frazier, Robert E.	026	Columbia
Garcia, Eduardo L.	190	St. Louis
Gavankar, Sharad S.	102	Joplin
Genovese, Ann C.	014	Mexico
Gonzalez, Alicia D.	190	St. Louis
Grossberg, George T.	190	St. Louis
Guze, Samuel B.	190	St. Louis
Hagen, Duane Q.	190	St. Louis
Hartnett, Anna E.	190	Clayton
Hartnett, Thomas D.	190	St. Louis
Hicks, Frederick G.	190	St. Louis
***Hogan, Patricia E.**	030	Maryville
Holemon, R. Eugene	190	St. Louis
Houghton, Howard L.	125	Kansas City
Hucke, Samuel T., III	125	Kansas City
Hudgens, Richard W.	190	St. Louis
Irvin, William M.	190	St. Louis
Jones, Georgia A.	190	St. Louis
Jones, Laird E.	082	Springfield
Katf, Nicola Y.	050	Kansas City
Khan, Khawla B.	002	St. Louis
Khojasteh, Saaid	002	St. Charles
Kitchin, Winston H.	190	St. Louis
Kleinschmidt, Donn C.	190	St. Louis
Klemm, J. Martin	125	Kansas City
Knowles, R. Raymond	190	St. Louis
Krojanker, David N.	190	St. Louis
Krojanker, Rolf J.	190	St. Louis
Kuhn, Lawrence F.	190	Bridgeton
Kulak, Gary	190	St. Louis
LeFevre, Philip J.	207	Washington
Lipschitz, Ervin	190	St. Louis
Lipschitz, Eve L.	190	St. Louis
Logan, William S.	125	Kansas City
Lucas, Thomas G.	190	St. Louis
Lyskowski, John C.	058	Jefferson City
Malmberg, Virgil L.	190	Chesterfield
Meyer, Jay L.	190	St. Louis
Milgram, Byron A.	125	Kansas City
Miller, Jule P.	190	St. Louis
Moran, Thomas M.	190	St. Louis
Moritz, K. Lynne	190	St. Louis
Mossinghoff, Deborah A.	125	Kansas City
Munro, John S.	125	Kansas City
North, Carol S.	190	St. Louis
Nowotny, Thomas J.	190	St. Louis
Ohlms, David L.	190	St. Louis
***Olomon, Angela S.**	050	Gladstone
Packman, Paul	190	St. Louis
Parks, Joseph J.	026	Jefferson City
Parwatikar, Sadashiv D.	190	St. Louis
Peterson, Stephen E.	125	Kansas City
Pew, Becky A.	190	St. Louis
Post, Stephen L.	190	St. Louis
Pribor, Elizabeth F.	190	St. Louis
Pro, John D.	125	Kansas City
Quiason, Arturo G.	125	Independence
Rankin, Diane	190	St. Louis
Richardson, Thomas F.	190	St. Louis
Robinson, Gordon H.	190	St. Louis
Ryall, Jo-Ellyn M.	190	St. Louis
Saghir, Marcel T.	190	St. Louis
Schmitz, John M.	125	Kansas City
Segraves, Steven D.	125	Kansas City
Shen, Winston W.	190	St. Louis
Shopper, Moisy	190	St. Louis
Simmons, Donald D.	125	Kansas City
Simon, Nathan M.	190	St. Louis
Sitzman, Everette T.	125	Kansas City
Slaughter, James R.	026	Columbia
Soorya, Narendir T.	190	St. Louis
Soto, Albert A.	190	St. Louis
Stewart, Harry A.	125	Kansas City
Tilzer, Seth	190	Florissant
Trikha, Ajit	002	Cahokia, IL
Vandivort, Paul M., Jr.	190	St. Louis
Viamontes, Jorge A.	190	St. Louis
Vickar, Garry M.	190	Florissant
Wolff, Harold D.	190	St. Louis

Public Health (MPH)

Biery, Richard M.	125	Kansas City

Pulmonary Disease (PUD)

Beller, Thomas A.	125	Kansas City
Bower, James S.	125	Kansas City
Brabson, John H.	082	Springfield
Brischetto, Michael J.	190	St. Louis
Brook, Charles J.	125	Kansas City
Devins, George S.	125	Kansas City
Goheen, John R.	125	Kansas City
Grimm, Mark E.	082	Springfield
Hargis, James L.	082	Springfield
Harrison, Garth F.	125	Kansas City
Heinz, George, III	082	Springfield
King, John V., Jr.	190	Ballwin
Lampton, Lawrence M.	026	Columbia
Lerner, Scott A.	125	Kansas City
Mahmoud, Said F.	125	Kansas City
Pingleton, William W.	050	Shawnee Mission, KS
Reddy, Anchala N.	206	West Plains
Scacewater, Rick	102	Joplin
Schlozman, Daniel L.	125	Kansas City
Siler, Thomas M.	189	St. Charles
***Thomas, Norvin E.**	014	Mexico

Radiation Oncology (RO)

Baglan, Robert J.	190	St. Louis
Bean, Joseph M.	026	Sedalia
Bedwinek, John M.	190	St. Charles
Bryer, Mark P.	026	Columbia
Cozad, Scott C.	002	Kansas City
Devineni, V. Rao	190	Bridgeton
Fu, Anna L.	190	St. Louis
Garcia, Delia M.	190	St. Louis
Gujarati, Subhash B.	034	Poplar Bluff
Lee, Fransiska A.	190	St. Louis
Lin, Hsiu-San	190	St. Louis
Marks, James	190	St. Louis

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Massey, Vickie	Kansas City	125
McDonough, Michael	St. Louis	190
Miller, Joseph P.	Cape Girardeau	042
Morrison, Richard A.	Independence	125
Myers, Duane E.	Joplin	102
Nigh, Stephen S.	Kansas City	125
Pacheco, Jose M.	Springfield	082
Perez, Carlos A.	St. Louis	190
Piephoff, James V.	St. Louis	190
Robinow, Jay S.	Kansas City	125
Roy, Tapankumar S.	St. Louis	190
Sheldon, John M.	Kansas City	125
Simpson, Joseph R.	St. Louis	190
Smalley, Stephen R.	Kansas City	125
Sutphen, Eric J.	St. Louis	190
Walz, Bruce J.	St. Louis	190
Zivnuska, Frederick R.	St. Louis	190

Radiology (R)

Abodeely, Daniel A.	Chesterfield	190
Al-Aly, Robert M.	Chesterfield	190
Albritton, Michael A.	Springfield	082
Anderson, D. Claire	St. Louis	190
Baber, William W.	St. Louis	190
Bardsley, John L.	St. Louis	190
Baula, Armindo G.	St. Louis	190
Berni, Anthony A.	St. Louis	190
Brown, Mike J.	Cape Girardeau	042
Busse, Paul P.	St. Louis	190
Campbell, William S., Jr.	Cape Girardeau	042
Carls, Garry L.	Imperial	190
Clouse, John W.	Springfield	082
Cohen, Edward	St. Louis	190
Cook, Marvin A.	St. Louis	190
Corder, Patricia G.	St. Louis	190
Crotty, John P.	St. Louis	190
Dehner, Jonathan D.	St. Louis	190
Diemer, Peter A.	St. Louis	190
Dixon, G. David	Kansas City	125
Dymond, John B., Jr.	Osage Beach	120
Elwing, Terry J.	Columbia	026
Francisco, Dominic S.	St. Louis	190
Gates, Mark L.	Cape Girardeau	042
Gilula, Louis A.	St. Louis	190
Gregston, J. Leon	Springfield	082
Habert, Edward R.	Chesterfield	190
Harris, Daniel E.	Cape Girardeau	042
Hassien, Joel D.	Hannibal	150
Hesker, Albert E.	Chesterfield	190
Higgins, Michael G.	Cape Girardeau	042
Hoskins, R. Bruce	Kansas City	125
***Huck, Elizabeth L.**	St. Louis	190
Jamroz, Greg A.	Washington	207
Judd, Jeffrey B.	St. Louis	190
Kays, Kenneth M.	Osage Beach	046
Kester, Nathan L.	Springfield	082
Kim, Stanley W.	St. Louis	190
Kotner, Lawrence M., Jr.	St. Louis	190
Krain, Samuel	Creve Coeur	190
Kronemer, Keith A.	St. Louis	190
LacKamp, Robert J.	St. Joseph	030
Lang, John J.	St. Louis	190
Leary, Daniel J., Jr.	St. Louis	190
Lenzenhuber, Karl J.	Washington	207
Link, Alexander J.	St. Louis	190
Logie, Macdonald B.	St. Louis	190
***Lovern, Royce E.**	Washington	207
Luisiri, Atchawee	St. Louis	190
MacDonald, Robert R., Jr.	St. Louis	190
MacNaughton, Robert A., II	Liberty	050
Mais, Thomas E.	Shawnee Mission, KS	125
McCown, Allan H.	St. Louis	190
Milburn, James M.	Chesterfield	002
Nepute, James A.	St. Louis	190
Niemeyer, John H.	St. Louis	190
O'Brien, Edward J., Jr.	St. Louis	190
Paskar, Larry D.	Chesterfield	190
Pepper, Edward G.	St. Louis	190
***Pfautsch, Mark L.**	Cape Girardeau	042
Phelan, David	Overland Park, KS	125
Pjura, George A.	Cape Girardeau	042
Prater, Kimberly A.	Springfield	082
Rall, Kenneth L.	Columbia	026
Reh, Thomas E.	St. Louis	190
Rezvani, Laghaieh	Sikeston	202
Rhodes-Stark, Kelly L.	Kansas City	125
Riaz, M. Afzal	Ste. Genevieve	174
***Ricci, Robert G.**	Leawood, KS	125
Rozen, Jay I.	Kansas City	125
Saboeiro, Gregory R.	St. Louis	002
Schulz, Richard C.	St. Louis	190
Shields, John B.	St. Louis	190
Shore, Jeffrey L.	Joplin	102
Smeltzer, Frederick M.	Osage Beach	120
Smith, Robert W.	St. Louis	190
Solomon, Steven L.	Chesterfield	190
***Steinberg, Lee M.**	Kansas City	050
Sweeney, Thomas P.	Springfield	002
Tailor, Chandrakant C.	St. Louis	190
Tellerman, Barbara J.	Columbia	026
Thompson, Robert F.	Kansas City	125
Vaslow, Dale F.	Jefferson City	058
Verde, Julian N.	St. Louis	190
Vierra, Michael J.	Osage Beach	120
Vijungco, Jose G.	St. Louis	190
Waldo, John P.	Cape Girardeau	042
***Weiss, Randy B.**	Joplin	102
Weyman, Philip J.	Chesterfield	190
Williams, Craig W.	Cape Girardeau	042
Zeigler, Joseph M.	St. Louis	190

Reproductive Endocrinology (REN)

Lyles, Rodney	Overland Park, KS	125
Starks, Gregory C.	Kansas City	125

Rheumatology (RHU)

Armstrong, Stephen D.	Springfield	082
Braun, Alan L.	Jefferson City	058
***Bronson, Wendell D.**	St. Joseph	030
Fischbein, Lewis C.	St. Louis	190
Huston, Kent A.	Kansas City	125
Lamonte-Jost, Daniel J.	Columbia	026
Layle, John K., Jr.	Kansas City	125
Schwartz, Howard R.	Springfield	082
Taylor, Philip W.	Cape Girardeau	042

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Therapeutic Radiology (TR)

Boles, Murray	Columbia	026
Lee, Lawrence E.	Kansas City	125
Murrell, H. Jerry	Columbia	026
Paradelo, Jorge C.	Kansas City	125
Rogers, J. Drew	Springfield	082
Westgate, Steven J.	Columbia	026

Thoracic Surgery (TS)

Bender, Edward	Cape Girardeau	042
Brown, Randy G.	Kansas City	125
Coordes, Cordie C.	Chesterfield	190
Eisenberg, Steven B.	Chesterfield	190
Fonseca, Peter	St. Louis	190
Garrett, Ted E.	St. Louis	190
Graham, Joseph E.	St. Louis	190
Gurucharri, Vincent P.	Columbia	026
Haybron, David M.	Columbia	026
Judd, Donald R.	St. Louis	190
Kraeger, Russell R.	St. Louis	190
Logue, William J.	Cape Girardeau	042
Marbarger, John P., Jr.	St. Louis	190
Murphy, J. Peter, Jr.	St. Louis	190
Naunheim, Keith S.	St. Louis	190
O'Sullivan, Daniel F.	St. Louis	190
Penn, Patrick L.	Kansas City	125
Ramsey, J. Darryl	Cape Girardeau	042
Reinhardt, J. Robert R.	Kansas City	125
Robison, Paul D.	Joplin	102
Ruess, Robert W.	Cape Girardeau	042
Sasser, William F.	St. Louis	190
Shaw, Richard C.	St. Louis	190
Stephenson, Hugh E.	Columbia	026
Strevey, Tracy E., Jr.	Frontenac	002
Sundt, Thoralf M.	St. Louis	002
Van Way, Charles W., III	Kansas City	125
Wathanacharoen, Suchint	Kansas City	125
Wilson, William R., Jr.	Columbia	026

Urology (U)

Abercrombie, Keith J.	Kansas City	125
Ahmann, Thomas M.	Mexico	014
Albani, Frank J.	Liberty	050
Aldridge, George A.	Poplar Bluff	034
Anglo, Luis J.	Ballwin	002
Apte, Sunil M.	Washington	207
Austin, George M.	Blue Springs	125
Biber, Robert J.	Independence	125
Blades, Ross D.	Springfield	082
Blath, Richard A.	St. Louis	190
Brehm, G. Scott	Joplin	102
Brodkey, Mark J.	Kansas City	125
Carpenter, James L.	St. Peters	189
Chehval, Michael J.	St. Louis	190
Cockrell, Steven N.	Hannibal	150
Cupp, Michael R.	Columbia	026
Deleste, Carlos J.	Festus	106
DeGuerre, Ronald K.	Chesterfield	190
Dresner, Steven M.	Columbia	026
Emeran, Georges J.	St. Louis	190
Falzone, John J.	Jefferson City	058
Fathman, Anthony E.	Chesterfield	190
Felker, J. Russell	Cape Girardeau	042
Foster, R. Steve	Sedalia	178
Frogge, Jim D.	Joplin	102
Gentle, Donald L.	Cape Girardeau	042
Gonzales, Jose H.	Perryville	174
***Hall, John P.**	Cape Girardeau	042
Hardy, David A.	St. Louis	190
Harrison, Winston E.	Columbia	026
Hawatmeh, Abraham S.	St. Louis	190
Herrick, Thomas B.	Kansas City	050
Holloway, Walter R.	West Plains	206
Itoku, Kendall A.	Chesterfield	190
Klein, Saul J.	St. Louis	190
Koonce, John P.	Jefferson City	058
Kozminski, Mike	St. Joseph	030
Kurtz, Karl J.	Kansas City	125
Lentz, Harold C., Jr.	Independence	125
Levy, Joseph	St. Peters	190
Lewing, David C.	Independence	126
Lierz, Mark F.	St. Joseph	030
Madduri, Sivaprasad D.	Poplar Bluff	034
Marcus, Michael D.	St. Louis	190
McCanse, Lynn R.	N. Kansas City	050
Milne, Jay L.	Springfield	082
Mitchell, John D.	Kansas City	125
Montie, Joseph E.	Columbia	026
Morgan, Willy J.C.	E. St. Louis, IL	190
Myers, George H.	Kansas City	125
Neuman, Neal	St. Louis	190
Nicolai, Charles H.	St. Louis	190
Parres, Jeffrey A.	Chesterfield	190
Partamian, Krikor O.	St. Joseph	030
Perinetti, Enrique P.	St. Louis	190
Reddy, Abbiah N.	Poplar Bluff	034
Ross, Gilbert, Jr.	Columbia	026
Saha, Nitai C.	St. Louis	190
***Scanlon, Robert C., II**	Springfield	082
Scheibe, Robert G.	St. Louis	190
Schermer, Jerrold A.	Columbia	026
Schmidt, Jerome H.	Jefferson City	058
***Schoenfeld, Roger H.**	Joplin	102
Scully, Thomas F.	St. Louis	190
Severance, Michael S.	Jefferson City	058
Shah, Jitendra P.	St. Louis	190
Shands, Courtney, III	St. Louis	190
Stanley, Brad K.	Independence	125
Sunshine, Herbert	St. Louis	190
Teague, J. Lynn	Columbia	026
Terry, James F.	Springfield	082
Thompson, Paul D.	Cape Girardeau	042
Torrence, Ralph J.	Chesterfield	190
Walters, Frederick P.	St. Louis	190
Wan, Shaw P.	Rolla	135
Weide, Allan R.	N. Kansas City	050
Weinstein, Stephen H.	Columbia	026
White, Brad C.	St. Louis	190
Wilson, William T.	Independence	125
Wise, Morris F.	Kansas City	125

Vascular Surgery (VS)

Adams, John G.	Cape Girardeau	042
Breeding, Lyle G.	Columbia	026
Cameron, Jeffrey W.	Kansas City	125
Campbell, Samuel J.	N. Kansas City	050
Cates, Joe A.	Kansas City	125
Del Santo, Peter B.	Columbia	026
Higgins, Edward F., Jr.	Kansas City	125
Humphrey, Paul W.	Columbia	026
Hurley, Joseph J.	St. Louis	190
Jacobs, Donald L.	St. Louis	002
James, Paul M., Jr.	Fulton	038
Mullins, J. Randolph	Springfield	082
Nichols, W. Kirt	Columbia	026
Schroder, William	Kansas City	125
Stark, Karl R.	Kansas City	125
Vogel, Curt M.	Columbia	026
Waldschmidt, Mike L.	Liberty	125

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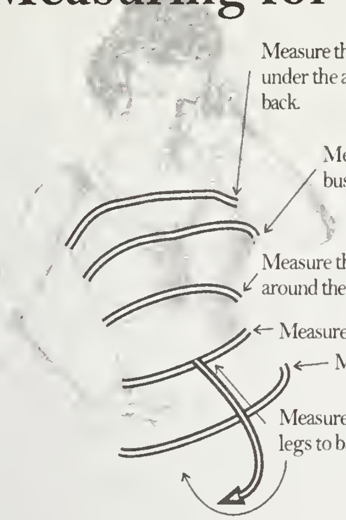
Measuring for a Custom Fitting



Measure the chest wall with a firm measurement taken as high under the arms as possible to under the shoulder blades in the back.

Measure the cup size (Bust) over the fullest part of the bust.

Measure the ribcage directly under the breasts and straight around the back.

Measure the waist line.

Measure the hips over the fullest part of the hip.

Measure from the front center of waist between the legs to back center of waist.

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9. Improve self-confidence
10. Relieve pain of cystic breasts
11. Stops moisture under the breast
12. Support from under the breast

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ADP	Addiction Psychiatry
AMI	Adolescent Medicine (Internal Medicine)
ADL	Adolescent Medicine (Pediatrics)
OAR	Adult Reconstructive Orthopedics
AM	Aerospace Medicine
A	Allergy
AI	Allergy & Immunology
ALI	Clinical Laboratory Immunology (Allergy & Immunology)
PTH	Anatomic/Clinical Pathology
ATP	Anatomic Pathology
AN	Anesthesiology
BBK	Blood Banking/Transfusion Medicine
ICE	Clinical Cardiac Electrophysiology
CTS	Cardiothoracic Surgery
CD	Cardiovascular Disease
CDS	Cardiovascular Surgery
PCH	Chemical Pathology
CHP	Child and Adolescent Psychiatry
CHN	Child Neurology
CBG	Clinical Biochemical Genetics
CCG	Clinical Cytogenetics
CG	Clinical Genetics
DDL	Clinical and Laboratory Dermatological Immunology
ILI	Clinical and Laboratory Immunology (Internal Medicine)
PLI	Clinical and Laboratory Immunology (Pediatrics)
CMG	Clinical Molecular Genetics
CN	Clinical Neurophysiology
CLP	Clinical Pathology
PA	Clinical Pharmacology
CRS	Colon & Rectal Surgery
CFS	Craniofacial Surgery
CCA	Critical Care Medicine (Anesthesiology)
CCM	Critical Care Medicine (Internal Medicine)
NCC	Critical Care Medicine (Neurological Surgery)
OCC	Critical Care Medicine (Obstetrics & Gynecology)
PCP	Cytopathology
D	Dermatology
DMP	Dermatopathology
DS	Dermatologic Surgery
DIA	Diabetes
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology, Diabetes and Metabolism
EP	Epidemiology
FPS	Facial Plastic Surgery
FP	Family Practice
FOP	Forensic Pathology
PFP	Forensic Psychiatry
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery
FPG	Geriatric Medicine (Family Practice)
IMG	Geriatric Medicine (Internal Medicine)
PYG	Geriatric Psychiatry
GYN	Gynecology
GO	Gynecological Oncology
HS	Hand Surgery
HNS	Head & Neck Surgery
HEM	Hematology (Internal Medicine)
HMP	Hematology (Pathology)
HO	Hematology/Oncology
HEP	Hepatology
IG	Immunology
PIP	Immunopathology
ID	Infectious Disease
IM	Internal Medicine
MPD	Internal Medicine/Pediatrics
LM	Legal Medicine
MFM	Maternal & Fetal Medicine
MXR	Maxillofacial Radiology
MFS	Maxillofacial Surgery
MG	Medical Genetics
MDM	Medical Management
MM	Medical Microbiology
ETX	Medical Toxicology (Emergency Medicine)
PDT	Medical Toxicology (Pediatrics)
PTX	Medical Toxicology (Preventive Medicine)
OMO	Musculoskeletal Oncology
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NRN	Neurology/Diagnostic Radiology/ Neuroradiology
NS	Neurological Surgery
NP	Neuropathology
RNR	Neuroradiology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
ORS	Orthopedic Surgery
OSS	Orthopedic Surgery of the Spine
OTR	Orthopedic Trauma
OFA	Foot and Ankle, Orthopedics
OMM	Osteopathic Manipulative Medicine
OTO	Otolaryngology
OT	Otology/Neurotology
APM	Pain Management (Anesthesiology)
PMD	Pain Medicine
PLM	Palliative Medicine
PTH	Pathology
PDA	Pediatric Allergy
PAN	Pediatric Anesthesiology (Pediatrics)
PDC	Pediatric Cardiology
CCP	Pediatric Critical Care Medicine
PE	Pediatric Emergency Medicine
PEM	Pediatric Emergency Medicine (Pediatrics)
PDE	Pediatric Endocrinology
PG	Pediatric Gastroenterology
PHO	Pediatric Hematology/Oncology
PDI	Pediatric Infectious Disease
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
OP	Pediatric Orthopedics
PDO	Pediatric Otolaryngology
PP	Pediatric Pathology
PDP	Pediatric Pulmonology
PDR	Pediatric Radiology
PPR	Pediatric Rheumatology
NSP	Pediatric Surgery (Neurology)
PDS	Pediatric Surgery (Surgery)
UP	Pediatric Urology
PD	Pediatrics
PM	Physical Medicine & Rehabilitation
PS	Plastic Surgery
PRO	Proctology
P	Psychiatry
PYA	Psychoanalysis
MPH	Public Health and General Preventive Medicine
PCC	Pulmonary Critical Care Medicine
PUD	Pulmonary Disease
RO	Radiation Oncology
RP	Radiological Physics
R	Radiology
RIP	Radioisotopic Pathology
REN	Reproductive Endocrinology
RHU	Rheumatology
SP	Selective Pathology
SM	Sleep Medicine
SCI	Spinal Cord Injury
ESM	Sports Medicine (Emergency Medicine)
FSM	Sports Medicine (Family Practice)
ISM	Sports Medicine (Internal Medicine)
OSM	Sports Medicine (Orthopedic Surgery)
PSM	Sports Medicine (Pediatrics)
CCS	Surgical Critical Care (Surgery)
SO	Surgical Oncology
TR	Therapeutic Radiology
TS	Thoracic Surgery
TRS	Trauma Surgery
TTS	Transplant Surgery
UM	Underseas Medicine
U	Urology
VIR	Vascular and Interventional Radiology
VM	Vascular Medicine
VS	Vascular Surgery

In addition to the above, the following specialty designations are also used:

OS	Other (i.e., a specialty other than those appearing above)
US	Unspecified

Members by Component Society

(Please note component societies are listed in alphabetical and numerical code order.)

Component Medical Society Codes

002	MSMA Only
010	Andrew
014	Audrain
018	Barton
026	Boone
027	Boone Residents
030	Buchanan
034	Butler-Wayne-Ripley-Carter
038	Callaway
042	Cape Girardeau
046	Chariton-Macon-Monroe-Randolph
050	Clay-Platte
054	Clinton
058	Cole
066	Dallas-Hickory-Polk-Dade
070	Dunklin
078	Grand River
082	Greene
085	Greene Residents
086	Henry
102	Jasper-Newton Metropolitan
106	Jefferson
110	Johnson
115	Laclede
118	Lafayette-Ray
120	Lake of the Ozarks
125	Metropolitan Medical Society of Greater Kansas City
126	Metropolitan Medical Society of Greater Kansas City Residents
135	Mid-Missouri
138	Mineral Area
146	Montgomery
148	North Central
150	Northeast
158	Northwest
166	Ozarks
170	Pemiscot
174	Perry-Ste. Genevieve
178	Pettis
189	St. Charles-Lincoln
190	St. Louis Metropolitan
195	St. Louis Metropolitan Residents
198	Saline
202	SEMO
206	South Central
207	Tri-County
208	Tri-Lakes
210	Webster
214	West Central
216	St. Louis University
218	University of Missouri - Columbia
220	University of Missouri - Kansas City
222	Washington University

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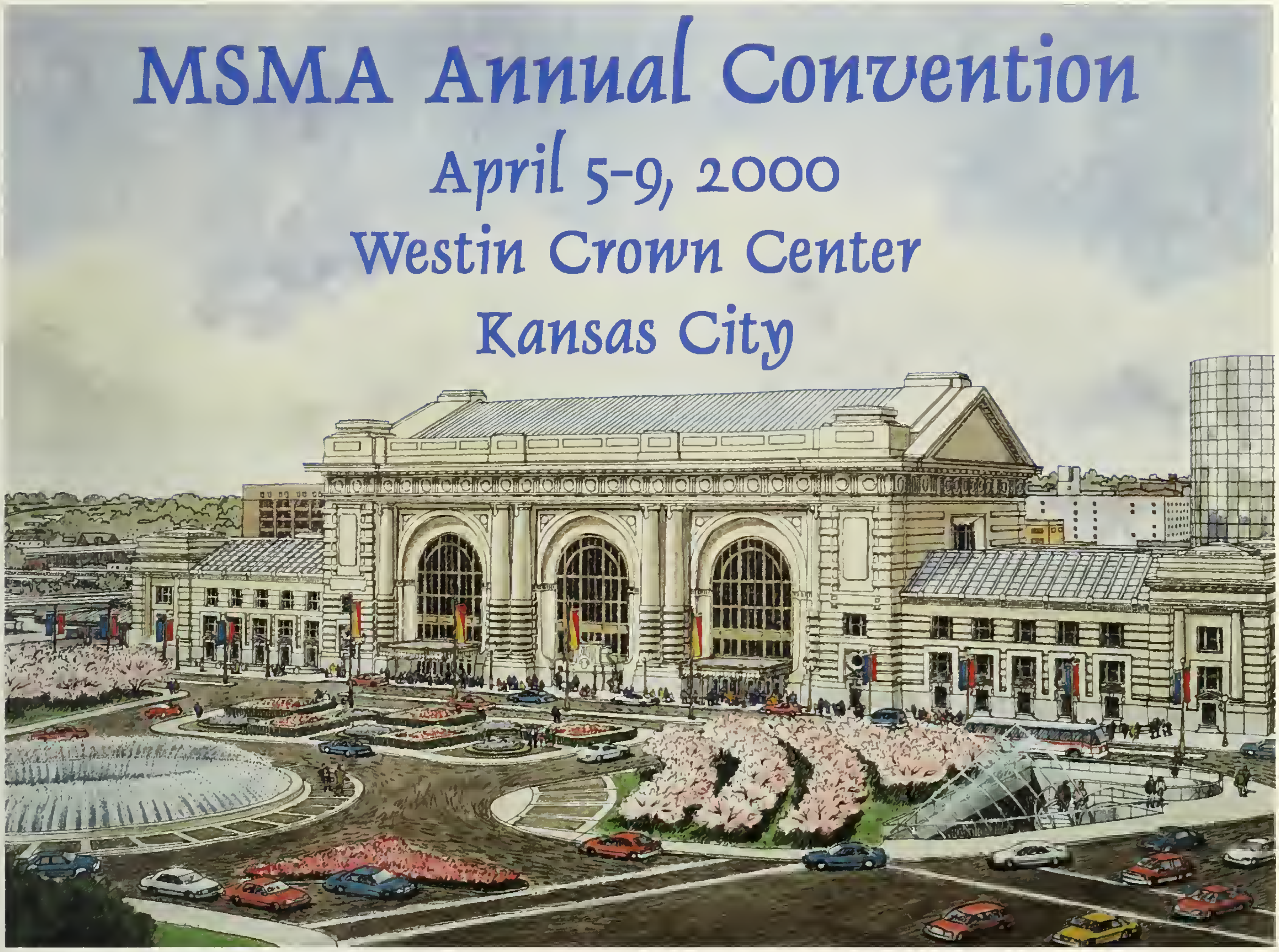

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On the Cover: "Tuscan Sunflowers" - by Henry Domke, MD. This started as a photograph taken while walking the back roads of Tuscany in Italy. Dr. Domke digitized the slide, then using the programs Photoshop and Painter, he removed some elements, adjusted colors and added a painted Impressionistic effect.

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"Sometimes It's More Than A Cigar"

J. Regan Thomas, MD

Cigars have been a surprisingly spared tobacco product. Spared the intense anti-tobacco regulatory action or the high profile attention that cigarettes or even the various forms of smokeless tobacco have suffered. In fact, there are many who smoke cigars thinking they are a safer alternative to cigarette smoking. Cigar stores, "cigar bars", and lounges have sprung up in nearly every city and cigar smoking is at an all time high. An *AMNews* staff member, Stephanie Stapleton, reported recently that cigar sales increased 15% from 3.8 billion cigars in 1996 to 4.4 billion in 1997. The trend continues until today. Although the cigar industry's advertising budget remains less than that of the cigarette industry ($41 million vs. $5 billion annually), the amount is increasing in all types of media. The FTC noted recently that cigar manufacturer's expenditures on movie and T.V. placements as well as celebrity endorsements has doubled in recent years.

The relative free ride may be over in terms of scrutiny of the health risks of cigars. The FTC last month released a report suggesting legislation requiring health warning on cigar labels similar to those found on cigarette packages. They recommended likewise a ban on television and radio advertising. At least two states now require such cigar labeling (Massachusetts and California) and recent possible federal legislation has been introduced in Congress.

The FTC suggests the following warnings on cigar labels:

Warning: Cigars are not a safe alternative to cigarettes.

Warning: Regular cigar smoking can cause cancers of the mouth and throat even if you do not inhale.

Warning: Inhaling cigar smoke can cause lung cancer. The more deeply you inhale, the greater your risk.

Source: *AMNews*

Although the public continues to harbor the misconception that cigars are safer (you don't "inhale", or the smoke is a cooler temperature are frequent comments by cigar smokers), the National Cancer Institute disagrees. Their studies support a link between cigar smoking and cancer. The recent FTC recommendations may change the public's perception but it will be difficult at first to overcome cigar smoking as a "trendy" activity. There are publications devoted entirely to cigar smoking. Both male and female celebrities are frequently pictured with a cigar. Many teenagers no longer see cigars as an old man's form of tobacco use. Instead it is a style conscious status symbol for young men and women.

If Congress fails to act appropriately, the FTC has the authority to require labeling independently of Congress. Having congressional support would add significant credibility and clout in the media and public consciousness.

Organized medicine should take a leadership role with cigars as they have with other forms of tobacco. Warning the public of the genuine health risk involved with smoking cigars should be a clear message from the medical community. Rationalizing it as safer than cigarettes only confuses the issue. "Cigars are bad for your health and increase the risk of cancer", should be an up front and direct message to all of our patients. MoMed

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Broadening of the Undergraduate Medical Education Curriculum

This is in response to the very thoughtful letter to MISSOURI MEDICINE from Micah R. Tepper, a fourth year medical student at the University of Missouri-Columbia School of Medicine that appeared in the July 1999 issue. I certainly am in full agreement with Micah Tepper's call for a broadening of the undergraduate medical education curriculum to include topics that reflect the changing environment in which medicine is practiced today.

As the former dean of the University of Missouri-Kansas City School of Medicine, I was approached in the early 1980s by graduates of that school asking why we didn't incorporate into the curriculum more content on how to manage a practice. Although we responded to that request with a course on practice management, it was not as widely subscribed to by medical students as it was by resident physicians. This example illustrates the importance not only of adjustments to the medical curriculum, but also consideration of when and where in the continuum of medical education such content is most appropriately placed.

At the Liaison Committee on Medical Education (LCME) in response to a number of requests regarding the incorporation of topics such as health care management, economics and policy into the undergraduate medical curriculum, we included a special question on this topic in our annual 1998-99 LCME questionnaire to U.S. medical schools. The results of that survey revealed that 108 of our 125 U.S. medical schools now include content matter on "Medical Socioeconomics" as part of a required course, with 17 schools offering an elective course on this topic. One hundred twelve of our 125 U.S. medical schools now devote, as part of a required course, content matter on "Health Care Systems" with 26 schools offering an elective course on this topic. The LCME, which accredits medical education programs leading to the M.D. degree, requires that socioeconomic subjects pertinent to medicine by included as part of the curriculum. It is apparent, therefore, that our medical schools are responding in an appropriate way to the call issued in the Tepper article.

Finally, Dr. Thomas, I want to thank you for the wonderful tribute you paid to the AMA and to your experience as an AMA delegate in your Editor's Desk article, *A Fond Farewell.* It was beautifully written and provides appropriate recognition of the importance of an organization that can speak for American medicine at this critical time in the history of our profession.

Harry S. Jonas, MD, LCME Secretary, 1999-2000
Vice President, Medical Education, AMA

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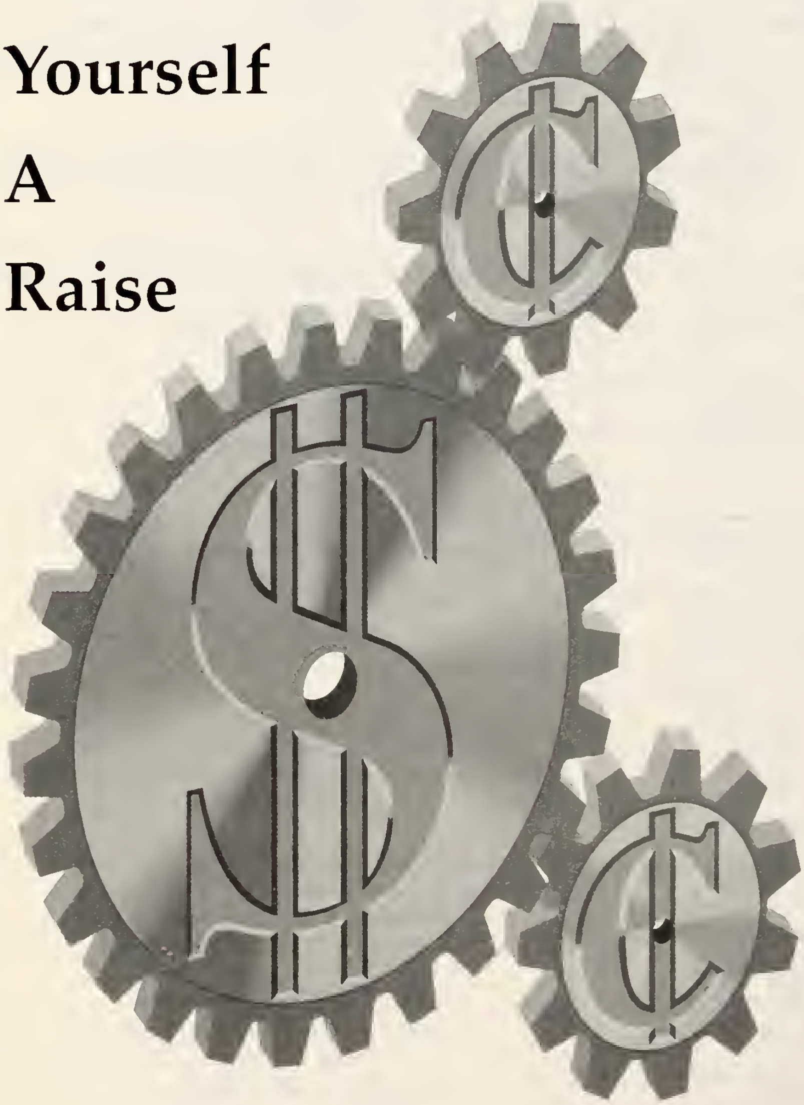

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Give Yourself a Raise

William Dorzab, MD

I'm excited about a new benefit now available to MSMA members – group medical malpractice insurance!

As a membership association, the Missouri State Medical Association has always been interested in meeting the needs of its members. While many physicians think of MSMA as being synonymous with legislative representation and interaction with the Board of Healing Arts, Department of Health, and Medicaid, - - we also have endorsed commercial products of interest to physicians.

Now, MSMA is introducing a medical malpractice liability insurance group-purchasing program which will have wide appeal.

This new, and I believe exciting program, available only to members of the MSMA, will allow physicians to have access to very low medical liability premiums from a highly rated insurer. Over the last six months, a committee consisting of Gordon Goldman, MD, President-Elect from St. Louis; Jerry Kennett, MD, 5th District Councilor from Columbia; and myself reviewed many alternatives and recommended to the MSMA Council that MSMA begin this program.

MSMA will be assisted in this program by Healthcare Insurance Services (HIS), an insurance broker from Houston, Texas, specializing in medical malpractice insurance. HIS acts as the insurance broker for approximately 40,000 physicians around the country and will be lending expertise to MSMA in designing a program for Missouri physicians.

MSMA is introducing a medical malpractice liability insurance group-purchasing program

You may have noticed that I have not mentioned a specific insurance company. This is because we will now be using a broker who will review bids from many large, highly-rated, insurance companies and assist MSMA in selecting the company offering the best package - - high quality and low rates. This group-purchasing program has the singular goal of being the best possible solution to many MSMA members' liability insurance needs.

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Health Adventure Center

Kathryn Anne Lucas and Ann Cohen

Grab a hard hat and join our groundbreaking celebration....construction on Health Adventure Center is underway! Health Adventure Center is a science center...a new and different kind of science center...an intriguing, high-tech, multi-million dollar facility developed with one purpose in mind...to help the individual, the family and the community achieve improved physical health and sense of well-being. Imagine immersing yourself in galleries of informative exhibits incorporating the latest in scientific and medical understanding designed to teach the visitor how to look and feel and do his or her best...exhibits exploring nutrition, fitness, healthy relationships, the immune system, mind/body connections plus much more.

Under development since 1990 in Columbia, Missouri, Health Adventure Center is a community response to the need for an effective approach to public health promotion and health education. One of Health Adventure Center's core beliefs is that achieving and maintaining health and a sense of well-being is key to leading a fulfilling and productive life. A second core belief is that the healthy lifestyle choices made by the individual affect not only personal health but also the health of the family and, by extension, the health of the entire community.

Health Adventure Center, under construction at the corner of 5th and Cherry Streets in downtown Columbia, enjoys the enthusiastic support of Missouri's medical, professional, educational and business communities, state and local government representatives, and most importantly, the general public. Individuals, families, school and community groups from across the state and beyond are invited to explore the Center's interactive exhibits and participate in demonstrations and presentations that motivate and support healthy behavior choices.

What can visitors expect to see inside Health Adventure Center? First, visitors will pass through the open lobby/gift shop area to enter the first floor exhibit hall. Pausing beneath a large, abstract model of the human brain, visitors will encounter the first of many "immersion" experiences. Here, visitors will get an overview of the exhibits in Health Adventure Center and will learn that healthy choices are under their conscious control. Further inside the exhibit hall, the Body Systems area provides information about human anatomy and physiology. This information will help visitors understand how their lifestyle choices affect their bodies and their sense of well-being. Other exhibit areas, including hand-washing, medical check-ups and health screenings, focus on disease prevention. A realistic Hospital Emergency Department, complete with ambulance, immerses the visitor in the drama of acute care with an emphasis on preventing trips to the Emergency Department.

Health Adventure Center's first floor also includes a Parenting/Early Childhood area. Children will be enchanted by a huge green tree, with ceiling-height spreading branches, growing in one corner of a room rich in exciting learning opportunities. Parents, grandparents and anyone nurturing children will find this area a valuable educational resource. Classrooms and a demonstration kitchen complete the first floor and will provide a gathering place for school and community groups, professional development for teachers and continuing education for health professionals.

The first floor exhibit hall is connected to the second floor by an elevator and by stairs. Visitors will be encouraged to use the stairs, where they can check their heart rate at the bottom step, climb the stairs, and re-check their heart rate at the top. A graphic panel will explain the relationship of heart rate to cardiovascular fitness.

Health Adventure Center's upper level exhibit hall includes an exciting array of colorful, high-tech immersion experiences. For example, the Fitness Gallery's trail to fitness allows the visitor to participate in the transformation of a "couch potato" into a strong, flexible, fit individual.

The Locker Room area informs visitors about a number of sports, including soccer, swimming, baseball, jogging, etc. Visitors also learn how to prevent sports injuries and how to protect themselves from the damaging effects of the sun. The Fitness Gallery's "Back Room," sure to be a popular stop for many adults, provides information about how to achieve a strong, active, pain-free back.

The Nutrition Gallery offers visitors a chance to understand how food choices affect their health and sense of well-being. A high-tech food carousel allows visitors to push a grocery shopping cart,make computerized touch-screen food selections and see what their choices represent in terms of nutritional value, energy, fat grams, total calories, etc. In the Nutrition Gallery's grocery store, restaurant and home environments, visitors learn how to make healthy food choices in the real world and how to prevent food-borne illness.

The Healthy Relationships Gallery surrounds visitors with a series of oversized greeting cards. These colorful cards, adorned with hearts, help to create memorable settings such as a family living room…a booth at the corner drug store…a porch swing. In these comfortable settings, visitors can explore important information about making healthy relationship choices throughout the human lifecycle. Issues relevant to adolescent growth, sexuality, pregnancy, marriage and the family, aging, etc. are treated with frankness and sensitivity.

The Immune Gallery immerses the visitor in a field tent environment where the drama of everyday human survival is carried out at the cellular level. Visitors learn how their immune system is constantly on guard, keeping infection at bay and repairing tissue damage. Visitors experience, through dramatic, computer-assisted presentations, which lifestyle choices can help keep their vital immune system functioning at peak performance.

The Mind/Body Gallery celebrates the role of the central nervous system, especially the brain, and pays homage to the mind as the ultimate control center of the human body. The ambience of this gallery, created by a series of large-scale brain scan images and hanging nerve-impulse mobiles, underscores the important connections between the realms of mental and physical. One of Health Adventure Center's fundamental themes is that heightened awareness of our minds and bodies leads to increased control over the life choices we make. This theme is echoed throughout the Mind/Body Gallery's exhibits. These exhibits include an interactive theater housed inside a replica of an over-sized brain, a visually dramatic exhibit on the dangers of addiction and substance abuse, kiosks demystifying mental illness through compelling first-person experiences, and a presentation entitled, "Laughter is the Best Medicine."

Health Adventure Center's upper level Changing Exhibit area will provide important, in-depth information on health-related topics, including vision, dental care, hearing, etc. A staffed Resource Room will provide extra meeting space, Internet access, health education materials, and help for any visitors, teachers, health professionals, etc. who wish to gather additional health information.

Health Adventure Center promises to be one of Missouri's most unique and outstanding facilities. The construction phase is estimated to last approximately 18 months. The Center anticipates greeting the new millenium with a grand opening in early 2001. MoMed

Health Adventure Center
welcomes suggestions for exhibit content
as well as exhibit funding.

Please contact Kathryn Lucas
c/o L.W. Lucas, M.D.
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Student Section News

University of Health Sciences

The University of Health Sciences in Kansas City is hosting the American Medical Association's Medical Student Section II Meeting October 9 and 10. Dr. Ronald Blanck, Surgeon General, U.S. Army will be the featured speaker. UHS was awarded the AMA's MSS "Chapter of the Year" Award for the 1998-99 school year for Section II at the AMA's June Meeting.

UHS is looking forward to recruiting new members from its incoming class of 220 students. Chapter plans include an organ donor awareness booth at the Northeast Fall Festival, and a fund raiser of chapter logo shirts to increase awareness of the MSMA-MSS.
Submitted by Mini Tandon

University of Missouri - Columbia

The School of Medicine at the University of Missouri - Columbia held its activities fair and membership drive in August. Plans for the annual Halloween Costume Party, "Terrortoma '99 ", which will raise funds for the chapter to donate to a Sedalia Health Clinic. UMC is also updating its student constitution.
Submitted by Eric Mullins

Washington University

The Washington University School of Medicine MSS held a luncheon discussion about the history and implications of the unionization announcement by the AMA. An organ donor event including hypertension screening was held on August 14. They are planning a scrub sale for incoming first-year medical students for 2000.
Submitted by Benjamin D. Unger

Resident News

A community service project involving preventive medicine and increasing resident and patient education and utilization of general medicine screening examinations will be held by internal medicine residents at Barnes-Jewish Hospital in St. Louis. Plans are also underway to work with the Medical Student Section for resident and student spouse contacts.
Submitted by Carolyn Morris, MD

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Johanna Echols has joined the MSMA as Director of Membership. She will be responsible for the recruitment and retention of physician members in western Missouri. Mrs. Echols will also liaise with state departments, staff the International Medical Graduate Section, and serve as the executive director of the Missouri State of Orthopaedic Association. Mrs. Echols, of Jefferson City, is formerly the membership director and assistant director of the Missouri Poultry Federation.

Becky Jungermann has been named managing editor of *Missouri Medicine*, the scientific and socioeconomic publication of the Missouri State Medical Association. The monthly magazine, with a circulation of 5,500, is distributed to MSMA members and medical libraries across the nation. Mrs. Jungermann, of Portland, previously served as assistant managing editor and as executive director of the Missouri Society of Anesthesiologists. Along with her new duties, she will be responsible for maintaining the Association's website: msma.org.

Benita L. Stennis has been named the Director of Field Services at the MSMA. Mrs. Stennis' duties include membership recruitment and retention for eastern Missouri. She will also staff the Young Physicians Section, develop a minority physicians program, and serve as executive director for the Missouri Society of Anesthesiologists. Mrs. Stennis, of Jefferson City, is formally the membership development director for the Heart of Missouri Girl Scout Council. She received a bachelor of arts in political science from Washington University.

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Eggs for Breakfast: Recalling the Cholesterol Debates

Philip C. Anderson, MD
with and concerning Margaret A. Flynn, PhD

Throughout the entire century, U.S. citizens have been exhorted unmercifully to live healthier lives. Among the major issues have been personal cleanliness, workplace safety, automobile safety, no tobacco, less whiskey, clean food and water, proper preventative medical and dental care, mental health and, most persistently, diet. In recent decades no issue has been so enthusiastically force-fed to the entire public as detailed directions for their daily diets. We notice particularly the effort to drive out eggs for breakfast.

For instance, since 1950 or so, all of us have been bombarded night and day through all public media, newspapers, TV, magazines, billboards, and radio, not to eat cholesterol. Some of these other diet campaigns have been based on little real evidence, experts have disagreed among themselves, TV producers have become bored and that food fad passes away. Many of these campaigns have been more emotional than intellectual. Has this tedious campaign against cholesterol been patient, truthful and thoroughly supported by medical evidence?

Near the center of the anti-cholesterol fad was the breakfast egg. Faddists immediately bumped eggs off the nation's breakfast menu. The egg is a graceful, natural ovate spheroid containing 200-300 mg of cholesterol. The yolk was a yellow capsule of dangerous cholesterol to its critics. Early on, at least by 1960, the egg became an icon in the cholesterol debates.

You are not "what you eat", despite the popular belief that you are.

Eggs deserve a better break. Think "moderation", think "lean", keep a varied diet and enjoy a few eggs.

Our senior author (M. Flynn), began publishing her studies of egg 20 years ago. In her childhood, on a Montana farm, she had watched family members eat heavily every day of butter, meat, milk and eggs. They were long-lived and healthy but all these hard-working farmers were lean, not obese. Their sizeable daily caloric intake matched their metabolic demands. Flynn doubted the deadly nature of cholesterol, and so she questioned the need to omit eggs from everyone's diet.

Those who abhor cholesterol insisted on national TV that cholesterol was the single active cause of disease. They have stated and implied that high cholesterol diets will cause cardiovascular disease, and all of you will die of it. The message is intended to frighten you into a vegetarian diet.[1] For those who eat no cholesterol, rewards would assuredly be great, at least to include a healthy heart and long life. Such overblown advertising does not explain individual risk or how diseases might interact. The message was unsophisticated.

The metaphor of cleanliness appears often. When blood vessels have yellow plaques, they are dirty, and we need to "clean them up." The healthy person "cleans out all the poisons," which includes cholesterol. At the same time, interestingly, vegetarianism became popular among young, anti-establishment journalists. For the fashionable few, all animal products were off the diet. "Cleaning out poisons" became a major health practice, involving sweating, mega-vitamins, fasting, minerals and special diets. "Flushing out poisons" involved a liter a day of bottled drinking water and occasional colonics. All of this was well received by much of the

U.S. public, who are always pleased with any plan that doesn't involve any weight loss or any less consumption of beer-wine-whiskey or any other attack on bad habits. A laxative type pill would be available to "clean out" the cholesterol. Good health would come in a pill. No need to worry.

Much of this advertising has proved to be exaggeration. Flynn's first studies showed that normal, active people eating common sense diets could add an egg or two every day without any change whatsoever in their serum cholesterol. Neither was it truthful that universally high cholesterol diets reliably will cause early death from heart disease. Nor did all strict, lifetime vegetarians enjoy freedom from atherosclerotic heart disease.[2] In fact, some people ingest enormous amounts of cholesterol, have plaques in vessels, but do not die early of cardiovascular disease.[3] Driving down serum cholesterol can't always be achieved by diet, even perfect diets. Many of our most elderly, most healthy people have high serum cholesterol.[4] Young people with normal serum cholesterol levels can die of cardiovascular disease.[5] Many of the obvious facts didn't fit with the too-easy notion of 'evil cholesterol'.

Dr. Flynn's comments:

I began studying effects of fresh whole egg consumption twenty-two years ago. My first study[6] *centered on effect of dietary egg on one hundred and fourteen healthy male volunteers with no history of heart disease, between thirty-two and sixty two years of age. Each ate one whole egg daily within their customary diets for three months. Their final serum cholesterol and triglycerides levels were compared with their initial levels on customary free choice diets and also, later with their cholesterol levels after three months' elimination of dietary whole eggs. Four-day food records were kept during both experimental dietary periods. A Latin squared design allowed analysis for seasonal effects on blood lipid levels. No significant change in serum cholesterol whatsoever, was found on either diet.*

Other similar studies were done with two eggs daily and no eggs in a crossover design.[7]

American Heart Association resisted these data verbally and in print, again and again, for years. Consumption of eggs by their recommendation was to be a "2 per week". Agricultural engineers worked on processes called "super critical liquid extraction" that could remove cholesterol from food products without affecting the food's nutrition and taste! Presently, twenty years after our egg studies, American Heart Association has admitted, "eggs won't hurt you". Also in April 1999, a dozen strong proponents of danger in egg consumption changed attitude via publication of data from two prospective epidemiology studies that showed a daily egg consumption is unlikely to have substantiated overall impact on risk of CHD or stroke,[8]

The Center for Science in Public interest sent a letter criticizing my views to the Editor of the Journal, which published my first study. Oddly, in the letter Hausman criticized my study because it involved free-living subjects choosing their own meals whereas other studies had controlled diets.[9] *My answer to that letter stated our study was not a metabolic study and what Center for Science sees as a limitation (i.e.) the effect of dietary egg examined within the framework of usual American diets, was actually what we wanted to know.*[10] *The Center for Science's references for the well-designed studies of the past research used crystalline reagent cholesterol dissolved in oil added to basic low fat, high protein diets that contained few animal products. Humans usually don't eat those kinds of diets.*

About this time another issue returned: whether saturated animal fat was "bad" in comparison to "good" polyunsaturated plant fat. My next research (1991) focused on 2 egg daily consumption of self-selected diet within either saturated fat (butter) or unsaturated fat (margarine) in a crossover design.[11] *Seventy-one men volunteers, 51 free-living normocholestrolemic and 20 hypercholesterolemic (> 240 mg day) participated. Four-day diet records of the volunteers in each interval showed subjects ate about 16% total dietary fat as either butter or margarine, Blood samples taken every 6 weeks showed variable mean serum, total cholesterol, HDL and serum triglyceride. Normocholesterolemic subjects who ate butter first had, by 24 weeks, mean total cholesterol values similar to their entry values; those who ate margarine firsthand increased total serum cholesterol throughout the study. By the end of the study the hypercholesterolemic subjects showed either no change or a slight decrease in total cholesterol and HDL. Specific fatty acids were distributed differently in the serum fractions of triglyceride fatty acids, cholesterol esters and* *phospholipids. These distributions remained constant in both normocholesterolemic and hypercholesterolemic subjects regardless of type and amount of fat consumed. We concluded eating 2 fresh whole eggs daily and adding butter or margarine to self-selected diets of normolipodemic and hypercholesterolemic human subjects showed different individual serum total cholesterol and HDL. In this study of small numbers of hypercholesterolemic humans who included eggs, butter, margarine in their self-selected diets, their serum total cholesterol did not appear to increase significantly. We did see that the entire composition of the diet was important, not only the cholesterol.*

Next I moved into meat research because I continued to be concerned with saturated fat: beef fat is "hard" fat (saturated) compared to poultry and fish, which have "unsaturated" fat.[12] I wondered what would happen if people ate eggs, (cholesterol) at the same time they also ate beef (saturated fat) or chicken - fish (unsaturated fat) or pork. One half of a group of 129 men and women (74 men and 55 women) in a crossover design ate, within a self selected diet, one egg and at least 5 oz. beef daily for two months while the other half ate one egg and at least 5 oz. of poultry and fish daily. Then they reversed their diets for 3 months. Blood samples for cholesterol, HDL and triglyceride throughout the 6-month study showed no statistically significant changes in the men. In the women triglycerides were higher when poultry and fish had been ingested. Forty-seven of the men and 17 women volunteered to continue this study by using 5 oz. of pork meat for 3 months.[13] No blood changes were found. These 2 studies show no influence of "meat" and its fat on serum total cholesterol within self-selected diets.

Again, Center for Sciences in the Public Interest sent a letter to the Editor of the Journal about our meat study.[14] This time the letter was coauthored by Director of Framingham Heart Study. They castigated the Journal for publishing such "poorly designed and uncontrolled study." Liebman (CSPI) and Castelli (FHS)wrote in the letter that our statement in our manuscript "a change in diet of a healthy population from beef to chicken and fish for lowering serum lipids may be premature" was unjustified because our volunteer subjects ate "uncontrolled diets" and our conclusion implied that avoiding foods high in saturated fat such as beef will not lower blood lipid levels. Our answer to Liebman and Castelli, published as a reply to their letter, stated they appeared upset with our words "may be premature" in our conclusion.[15] We stated they "may not understand" the thrust of our study: that we had not studied heart disease and that we did not claim metabolic study and the title of our manuscript did not cite heart disease. We stated that what they see as a limitation in our design (i.e. effect of a reasonable amount of meat and egg within a framework of usual American diets) was actually our major goal. We cited a letter cosigned by Castelli and Kannel, both physicians, which had appeared in the Lancet 1979, in which they stated "it must be admitted that the results achieved in trials to reduce CHD risk by drugs or diet designed to lower serum-total cholesterol content have been disappointing.[16]

Whenever we choose to take a medical issue into the public arena, and whenever we opt to interact with journalists, we must anticipate a confusing and chaotic misadventure. The public is a good bit crazy concerning diet, and the press/TV is inept in reporting science. The core of good science is methodology, and most journalists or TV pundits can't understand such methodology. Flynn's studies of eggs for breakfast re-asserted a reliance on old-fashioned facts, better methodology and raised the flag of skepticism.

Modesty goes with skepticism, but modesty doesn't play well on TV. Given all there is to know, our knowledge of cholesterol is tiny. We know almost nothing about the beneficial effects of cholesterol, especially in embryogenesis, hormone balance, and brain metabolism. We need to admit modestly our lack of full knowledge. For much of the public, cholesterol simply was a "toxin" to be avoided. This overblown campaign against cholesterol was not justified by the facts. In fact, still today we remain dubious that a high cholesterol in an otherwise healthy person foreshadows any shortening of life at all. We recently became aware that systemically administered lipid-lowering drugs can induce eczema,ichthyosis or psoriasis as side effects.[17]

Flynn had many critics who actually believed that her advocacy of a couple of eggs for breakfast would harm the pubic health. Many of the critics were preoccupied only with patients who were at risk of heart disease at an early age. These critics generalized their concerns to all the public. Amusingly, Flynn was accused of being a paid agent of the big poultry corporations. Actually, the eggs for the first study in 1979 were laid by the non-corporate academic chickens in the University of Missouri chicken coops. Flynn never was a beneficiary of the commercial egg corporations. No big bonuses, no perks. She remains still today poor but independent.

The retrospective evaluation of the ill-advised 'no-eggs' fad of the last 50 years is that it has crested and now is fading away. We favor a more reasoned concern to limit total calories and avoid obesity. Those Montana farmers of Flynn's childhood were hardworking and lean. Lean is important, unfortunately for many of us. Diet issues must be considered in context with genetics, tobacco use,alcohol abuse, dangerous drugs, infections, thyroid disorders, diabetes, obesity and more. No person is simply a "nutrition machine".

In recent years, some authorities have come to appreciate the benefits of eggs in the diet. Very low cholesterol suggests illness, often renal or hepatitic. One current study, unconfirmed, declared that patients who were diagnosed as depressed and anxious seemed to be deficient in cholesterol as compared to normal people.[18] Driving down cholesterol with drugs has some adverse effects. Can you eat too many eggs? Consider the famous "eggman" who ate two to three dozen every day. He thrived.[19]

Overall Flynn preached common sense as well as proper methods in science and skepticism. One good diet that everyone might consider is to eat the way your long-lived healthiest family members eat. There are numerous, different good diets; fads are seldom useful. We ought to guess that our bodies can manage a diverse diet. Intuition is an asset in good science. Cholesterol can not be considered a poison today because we now know it is a metabolic superstar of impressive diversity, essential to life. Flynn's defense of the egg drew on the intuition that cholesterol is necessary and natural for our bodily processes. It is no error that a mother's milk is rich in cholesterol. The breakfast egg is shedding its bad image. Commonsense and good science win in the long run. Eggs for breakfast are back again.

Dr. Flynn concludes:

You are not "what you eat", despite the popular belief that you are. Individuals, families and even populations vary greatly in the way they respond to items in the diet.[20] Genetics is the dominating risk factor in atherosclerosis.

Eggs deserve a better break. Think "moderation", think "lean", keep a varied diet and enjoy a few eggs. MoMed

Dr. Flynn has taught nutrition to two entire generations of medical and nursing students at the University of Missouri - Columbia. In her mid-80's, she is still the first in to the hospital every morning. She publishes regularly in several premier medical journals. She loves a good argument.

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Access to Health Care Services Among People with Disabilities Receiving Medicaid

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Abstract

Few data exist describing Medicaid's success in providing health care services to people with disabilities. The access to care survey from the Medical Expenditures Panel Survey was used to collect access data from 502 individuals with disabilities in central Missouri receiving Medicaid under fee-for-service reimbursement. Nearly all of the respondents had a usual source of care, but two-thirds reported difficulties obtaining a needed health care service. Dental, optometric, and personal assistance services were most difficult to obtain. Provider non-participation, non-coverage of a service, and coverage restrictions were the most frequently cited barriers to obtaining care. Results suggest that people with disabilities have difficulty accessing needed health care services through the Missouri Medicaid fee-for-service system.

Introduction

Medicaid continues to be the largest purchaser of health care services for the neediest and poorest people in the United States. Although nearly half of all Medicaid beneficiaries[1] are now enrolled in managed care systems, the majority of individuals with disabilities have remained in fee-for-service Medicaid. In Missouri, managed care enrollment is focused geographically in the Kansas City, St. Louis and central Missouri regions. Like many other states, Missouri, has focused on enrolling people qualifying for Medicaid based on the Temporary Assistance for Needy Families (TANF) criteria. Although some children with disabilities have been enrolled in managed care programs by nature of their TANF status, most people with disabilities continue to receive their health care services through fee-for-service Medicaid. The Division of Medical Services (Missouri Medicaid), of the Department of Social Services is beginning to explore new models of care for people with disabilities. For example, the Missouri Medicaid Coordinated Care System Project is a new initiative for people with disabilities and the elderly. This project is examining strategies for creating a seamless, integrated system of care that maximizes consumer choices in a cost-effective manner.

Across the U.S. state budget developers and policy makers frequently refer to statistics indicating that people with disabilities and chronic conditions represent approximately 27% of the Medicaid population, yet account for a disproportionate 72% of Medicaid's costs.[2] Despite the substantial health care resources directed toward this population, people with disabilities receiving Medicaid continue to report problems accessing health care services. The purpose of this study is to document access to health care needs among people with disabilities who receive Medicaid in central Missouri.

Literature Review

The Robert Wood Johnson Foundation (RWJF) has sponsored four national health care surveys that gathered access data among the general population.[3] Findings from the 1994 survey revealed that over 16 percent of respondents were unable to obtain at least one needed service.[4] Factors affecting access to care included income level, absence of a usual source of care, and insurance status. Persons with incomes less than $20,000 were three times more likely to have difficulty obtaining necessary services than individuals with incomes above $50,000. Respondents with no usual source of care (22%) were less able to access desired services compared to respondents who had a usual source of care (15%). Individuals without health insurance were two and a half times more likely to have an unmet need than consumers with health insurance. Respondents reported problems accessing dental care (8.5%), prescription drugs (6%), eyeglasses (5%), and many other services.[4]

Gold and colleagues[5] have re-analyzed access data from two previous nationwide studies to compare access to health care services for disabled Medicare beneficiaries in fee-for-service and disabled beneficiaries enrolled in capitated Medicare plans. Overall, Gold & colleagues found that disabled HMO enrollees were more likely to experience access problems than disabled fee-for-service enrollees (21-25 percent versus 14 percent), although both groups experienced significant access problems. Although studies such as these have demonstrated the difficulty that Medicare beneficiaries with disabilities have had in accessing health care, the literature contains few studies that focus specifically on people with disabilities receiving Medicaid. The recent access studies suggest that people with disabilities receiving Medicaid are more likely to experience barriers to service than people with other forms of health care insurance.[4, 5, 6]

The current study provides needed baseline data on access to care under a fee-for-service reimbursement model for individuals with disabilities receiving Medicaid in central Missouri. The objectives of this study are to identify health care services that are difficult to access, identify the barriers to obtaining services, and to evaluate the impact of these access difficulties on daily routine and physical health or emotional health.

Methods

The "Access to Care for People with Disabilities Survey" is a 115-item structured interview adapted from the Medical Expenditures Panel Survey developed by the Agency for Health Care Policy and Research and the National Center for Health Statistics.[7,8] Participants were asked about their insurance coverage, their hospital and emergency room utilization, their usual source of health care, the health care services they needed during the past 12 months, difficulties they experienced accessing needed services, whether access difficulties affected their health, ultimate success/ failure to receive needed services, self-reported health status, and history of medical conditions. Questions were added to address concerns common to people with disabilities such as issues relating to personal assistance services, durable medical equipment and specialty physician care. A question about failure (versus difficulty) to receive a needed service was added to the survey for the last 177 respondents.

The sample was drawn from a database obtained from the State of Missouri, Division of Medical Services (Missouri Medicaid). The database contained the names of 2,856 individuals who were receiving Medicaid under the fee-for-service reimbursement system, were classified by Medicaid as "permanently and totally disabled," and were living in a nine county region in rural central Missouri.[9] Telephone numbers were listed for only 38% of the individuals in the original Medicaid database. The University of Missouri Health Sciences Center computerized patient records system was used to obtain current addresses and telephone numbers for individuals who did not have a telephone number in the original database. The University of Missouri Health Sciences Center is a principal provider of health care for people with Medicaid in central Missouri. Telephone numbers were obtained on 2,331 of the individuals listed in the database. Postcards were sent to potential participants explaining the nature of the study. Potential participants were informed that they would be contacted at home and invited to participate in a telephone interview within two months. The postcard also reassured Medicaid beneficiaries of confidentiality of information and of voluntary participation. A 30-minute structured telephone interview was administered to individuals who provided consent. Surveys were conducted between October, 1996 and August, 1997.

Three attempts were made to reach each participant by telephone. Names were selected randomly until a sample of 550 was obtained; this required attempts to contact 1,797 individuals. If a call to a potential participant resulted in an answering machine, messages were not left in order to protect the privacy of the participants. Unsuccessful attempts to contact potential respondents were due to the following reasons: wrong telephone numbers (603), answering machines, no answer, or busy lines (418). In addition, 131 interviews were not completed for the following reasons: temporarily absent or unavailable due to illness or other reasons (102), 3 unsuccessful attempts to reschedule the interview (15), no proxy available (9), or deceased (5). Only 95 of the remaining individuals (14.7%) actively refused to participate. Of the 550 completed interviews, forty-six of the respondents did not have Medicaid for the past 12 months and 2 individuals resided outside of the 9-county geographic area, resulting in a final sample of 502.

Results

SAMPLE CHARACTERISTICS

The final sample consisted of 311 women and 191 men, who were predominately Caucasian (86%) and resided in a predominately rural geographic region. The mean age was 39 years (s.d.=16). Forty-two percent of the sample had less than a high school education, 30% had a high school education, and 28% had education beyond high school. Sixty-one percent of respondents were enrolled in Medicaid only, 30% received Medicaid and Medicare, and 9% had some form of private insurance and Medicaid.

The most frequently reported health conditions experienced by respondents included arthritis (42%), depression, (41%), breathing problems (41%), heart problems (33%), and anxiety (31%; Table 1).[10] Ninety-eight percent of the respondents had a usual source of care. The most frequent place respondents reported getting their care was a doctor's office or private clinic (38%), followed by a University clinic (32%), a public clinic (13%), and a hospital outpatient clinic (11%). During the previous 12 months emergency room (mean = 1.6 visits), overnight hospital stays and nursing home admissions (mean = .67 visits) were uncommon. Respondents reported frequent telephone and outpatient contacts (mean = 35) with their health care providers, however. Most respondents (86%) had visited their primary care physician during the last 6 months.

Table 1. Reported Health Care Conditions

Medical Condition	*No. of Respondents	% of Respondents
Arthritis	209	42%
Depression	207	41%
Breathing Problems	206	41%
Heart Problems	165	33%
Anxiety	157	31%
Ulcers in Stomach/Intestine	111	22%
Diabetes	86	17%
Traumatic Brain Injury	76	15%
Dermatitis	75	15%
Stroke	55	11%
Blood Disorders	51	10%
Hearing Loss	50	10%
Alcohol/Drug Use	49	10%
Loss of Sight	40	8%
Spinal Cord Injury	30	6%

*Respondents were allowed to report more than one condition

ACCESS TO HEALTH CARE SERVICES

Ninety-nine percent of the sample reported needing at least one health care service during the previous twelve months. Services most frequently used by respondents included prescription medications (86% of respondents), primary care physician services (78%), specialty physician services (71%), dental care (58%) and counseling (30%) (Figure 1). Two-thirds (66%) of those individuals who needed a service, reported difficulty accessing the service. The most difficult services to obtain include: dental care (73%), personal attendant services (49%), eyeglasses (32%), therapy for memory and concentration (32%), medical equipment (28%) and counseling (23%) (Figure 2). Of those individuals who had difficulty obtaining a service, 71% reported that this difficulty affected their daily routine, physical health or emotional health.

FAILURE TO OBTAIN A NEEDED SERVICE

Of those individuals who reported difficulty accessing a service, one hundred and seventy-seven respondents were asked about failure to obtain a needed health care service. Nearly half of all respondents (44.9% or 101 individuals) ultimately failed to receive a service that they desired during the past 12 months. Over half of all respondents (56%) who needed dental care did not receive this service.

BARRIERS TO ACCESSING HEALTH CARE SERVICES

Sixty-three percent of respondents had difficulty accessing a service because the provider did not accept Medicaid. Other reasons frequently given for access difficulties included Medicaid does not cover service (32%), and Medicaid covered the service, but did not approve enough hours or had restrictions on the services (16%) and difficulties getting an appointment (13%). Respondents frequently gave more than one reason for access problems. Twenty-two percent of the respondents stated a reason that was reported fewer than 10 times by other respondents (listed as "other" category; Figure 3).

OPINION OF HEALTH AND ACCESS

Access reports were examined in relation to respondents self-reported health status. Respondent's perceptions of their health were as follows: excellent (6.2%), very good (13.4%), good (25.5%), fair (32.7%), and poor (22.2%). In general, poorer health status was associated with increased difficulties obtaining health care services. The exception was that those who described their health as "excellent" reported a high rate of access problems. It should be noted, however, that the sample size for this cell was very small, potentially making the reports on access from this group unreliable (Figure 4).

Figure 1. Services Most Frequently Used by Respondents
Percent of Respondents

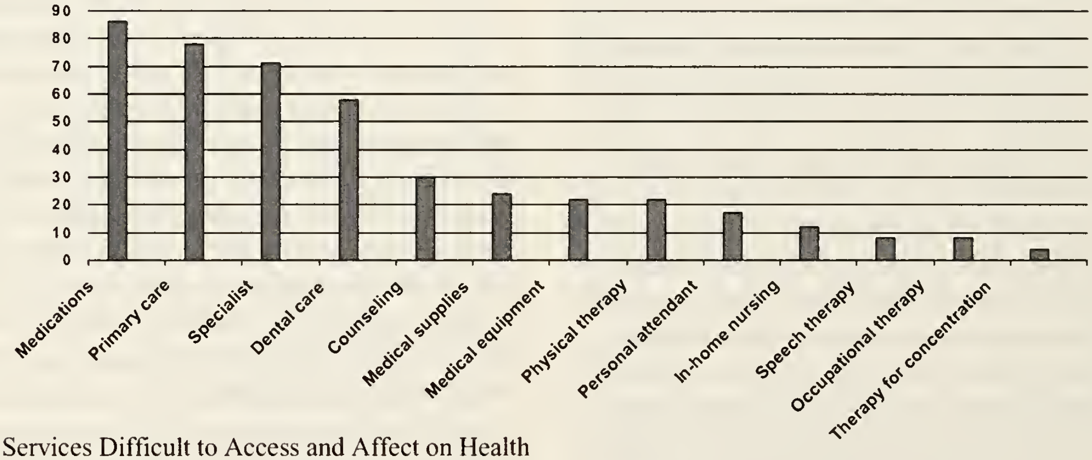


Figure 2. Services Difficult to Access and Affect on Health
Percent of Respondents

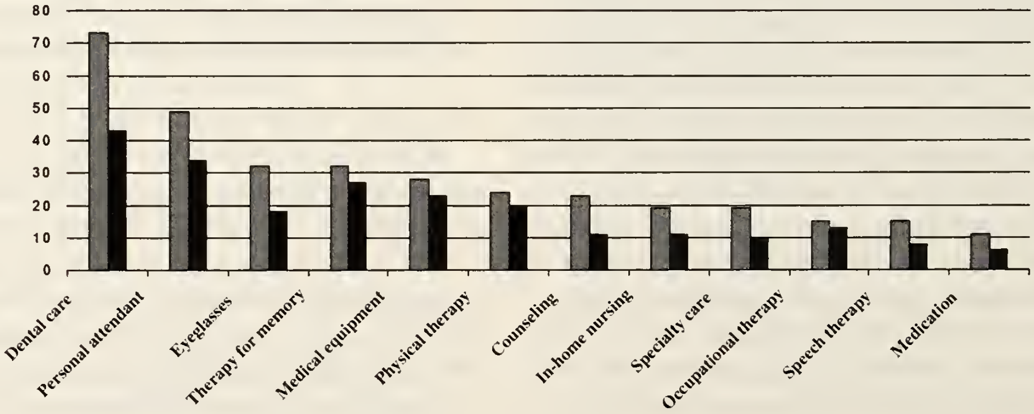
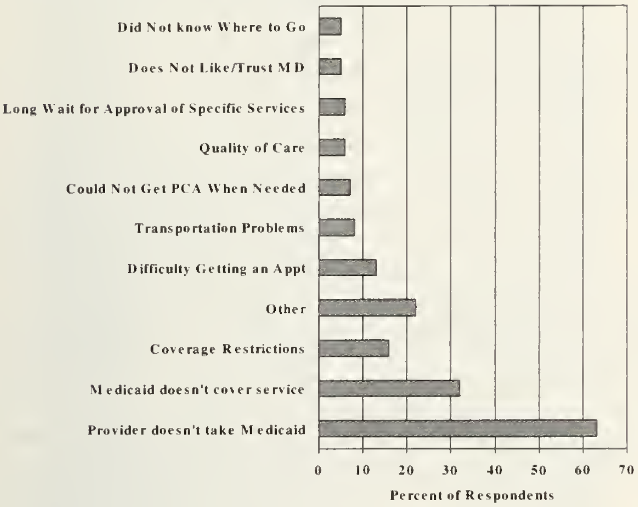


Figure 3. Barriers to Accessing Services



*Respondents were allowed to report more than one barrier.

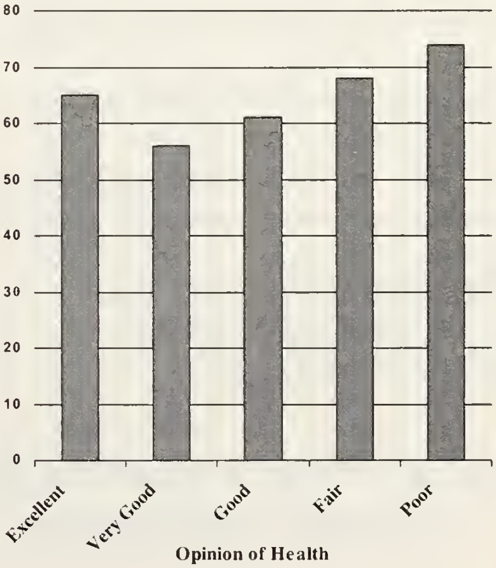
Conclusions

The results of this access survey indicate that a substantial hole exists in the Medicaid component of the "safety net." Significant gaps in health care services were revealed for people with disabilities receiving Medicaid in a fee-for-service system. Most respondents described difficulty when accessing health care services and stated that this difficulty affected their daily routine, physical or emotional health. The majority of respondents reported that access difficulties occur because the identified providers did not accept Medicaid. Most respondents (73%) reported difficulty accessing dental care, reflecting low provider participation rates under the Missouri Medicaid fee-for-service system. A majority of respondents (55%) also described their own health as either fair or poor. These respondents were more likely to have difficulties accessing services than individuals who reported better health. Although a directional causal relationship can not be determined with this data, poor access to needed services and poor health are likely to have a negatively synergistic effect on overall quality of life.

The results revealed a higher prevalence of access problems among people with disabilities when compared to previous studies conducted among both disabled Medicare beneficiaries and the general population. These comparisons should be reviewed with caution since the current study did not include a comparison group. Sixty-six percent of current study respondents reported access problems and 45 percent of a subsample of respondents stated that they never received the service. In contrast, only 16 percent of respondents in the RWJF study were unable to obtain at least one service that was needed.[4] Likewise, Gold and colleagues' analysis of a survey revealed access difficulties among 14 percent of fee-for-service respondents and 21-25 percent of managed care enrollees.[5, 6] Considering these results, it is important to note several relevant differences in the study methodologies.

The following access question was used in the current study for disabled Medicaid recipients, "Was there a time when you needed [insert type of service]?" If the respondent answered "yes," the interviewer would then ask, "Did you have any difficulty with it?" This question yielded a 66% affirmative response rate. This question is more open-ended than those in previous studies because it addresses not only whether or not a respondent failed to obtain a service, but if there were other

Figure 4. Opinion of Health and Access
Percent of Respondents Reporting Access Problems



problems involved in obtaining the service. During the pretesting period, data collectors reported that important information was lost if the question was limited to problems "obtaining" a service. For example, several respondents reported that they were able to obtain a service but experienced dissatisfaction related to discriminatory "attitudes" by provider and subsequently preferred to avoid seeking the service. Wording differences in the initial access question may have contributed to more frequently reported problems encountered by the respondents in the current study than in previous research. Nevertheless, when this survey asked about failure to obtain a needed service, 44% responded affirmatively.

Despite the methodological differences between this and previous surveys, the high level of failure to receive a service in the current study is believed to reflect the increased access problems encountered by people with disabilities. The substantially greater access difficulties found by this survey may be due to the socioeconomic differences of the target populations and to differences in covered services and reimbursement rates. For example, Medicaid programs typically provide significantly lower reimbursement than both Medicare and commercial insurance plans. The data revealed in this study and the other recent access surveys reveal consistently higher rates of access problems among people with chronic illnesses and disabilities, especially those from lower socioeconomic groups (i.e., Medicaid beneficiaries). Clearly, increased policy attention to vulnerable populations is warranted.[3, 4, 5, 6]

Because the sample for this study was drawn from a limited suburban/rural geographic area, caution should be used in extrapolating these results to other regions of Missouri or other states because of potential differences in the populations of interest, economic conditions, health care workforce, state Medicaid policies, etc. Nevertheless, most state

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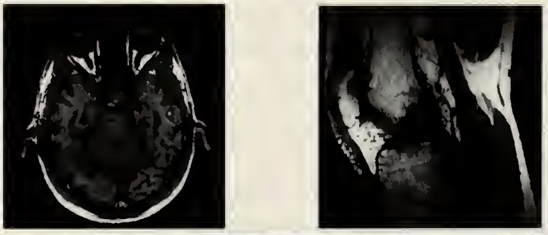

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Medicaid agencies are faced with similar challenges in providing adequate health care to vulnerable populations without sufficient data or knowledge about the service needs of these populations and with limited financial resources.

States rarely have empirical data about the complex health care needs of people with disabilities or data on access to primary, specialty, and preventive health care. States using fee-for-service reimbursement, however, are likely to be wasting limited health care dollars paying for high-end technological care for health problems that could have been prevented with improved access to community based services. Without available data on the health care needs of people with disabilities and the demand for services, it becomes very difficult to make resource allocation decisions or to determine how services should be coordinated to provide the greatest value.[11] Furthermore, consumers with disabilities are not obtaining their best health outcomes and some may be further harmed because of inadequate delivery methods.

Data about service needs for disabled Medicaid beneficiaries is not available or analyzed among most states. Even with such data, however, access problems may persist. For example, Gold and colleagues' analysis of access among disabled Medicare HMO enrollees found reported difficulties with obtaining referrals to specialists, hospital admissions, and sufficient home health care. Nevertheless, once service needs data are available to Medicaid agencies, this information can be transformed into purchasing criteria that must be met by MCOs that desire to provide health care services to vulnerable populations.

Furthermore, few states currently provide comparative data to health plans or to their consumers. Likewise, few health plans are targeting quality improvement criteria in any area of disability care and many state Medicaid agencies have reported the need for technical assistance to develop indicators to address quality of care for people with disabilities.[12] Consumers, health plans and providers will benefit from data on provider and health plan outcomes, such as satisfaction levels, access to care, quality of care, health outcomes and costs. Such information empowers consumers to make informed choices about the care they receive and provides the opportunity for state Medicaid agencies and health plans and providers to creative flexible, effective health care systems to meet the needs of people with disabilities.[13] MoMed

Acknowledgement

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9. In Missouri, individuals with disabilities qualify for Medicaid benefits based on Supplemental Security Income (SSI) criteria for "ermanent and total disability" and income. Individuals are determined to qualify at the county level and the medical condition that contributes to qualifying for SSI is not readily available in the aggregate database maintained by the state Medicaid office.
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Trends and Patterns in Colorectal Cancer Incidence and Mortality in Missouri

Katie A. Stamatakis, BA; Eduardo J. Simoes, MD, MPH; Jian Chang, PhD

Introduction/Background

Colorectal cancer is the fourth most common cancer in the world, accounting for 8.5% (875,000 cases) of worldwide cancer incidence.[1] Globally, colorectal cancer has been characterized as having a greater burden in more developed countries.[2] The high risk areas of North America, Europe and Australasia contribute to over 63% of global colorectal cancer incidence. In Missouri, as in the US, colorectal cancer ranks third in overall cancer incidence and mortality, accounting for 10.0% of all cancer deaths, and 14.3% of overall cancer incidence in the state.[3,4]

Colorectal cancers are believed to usually begin development as neoplastic adenomatous polyps of the intestinal wall.[5] While there is no direct evidence for this mechanism, it is supported by an abundance of indirect evidence from both laboratory and epidemiologic studies.[6] Adenocarcinomas account for about 98% of malignant colorectal cancers.[2]

Research has demonstrated that the risk of developing colorectal cancer is mediated by both hereditary and environmental risk factors. An estimated 10-15% of colorectal cancers are due to familial and hereditary factors.[5] These factors include the conditions of familial adenomatous polyposis (FAP) and hereditary nonpolyposis colorectal cancer (HNPCC) syndromes, as well as having first-degree relatives with colorectal cancer or adenomatous polyps.

Environmental and behavioral factors are believed to have the greatest impact on the risk of developing colorectal cancer. The geographic variation of colorectal cancer worldwide, in addition to the documented change among migrant populations from the incidence rate of their country of origin to that of their host country, supports the findings of other studies that environmental and behavioral characteristics are strong determinants of risk for colorectal cancer.[7,8,9] Of the modifiable risk factors, physical activity and diet probably play the most important roles in colorectal cancer development.[2] The evidence is convincing that people who maintain a physically active lifestyle throughout their life are at a decreased risk of colorectal cancer.[2,5,10,11,12,13,14,15] Likewise, there is convincing evidence that vegetable, though not necessarily fruit, consumption decreases the risk of adenomatous polyps and colorectal cancer.[2,5,16,17,18,19] This may be due to the protective effect of fiber and the anticarcinogenic effects of many of the micronutrients contained in vegetables.[2]

There are several other nutritional and environmental factors that may be related to colorectal cancer risk. High levels of alcohol, fat, sugar, red meat and heavily cooked meat consumption as well as cigarette smoking have been associated with an increased risk of colorectal cancer.[2,5,20,21,22,23] An accumulation of recent evidence indicates that aspirin and post-menopausal hormone use may decrease the risk of colorectal cancer.[24,25,26,27,28]

This paper examines the burden of colorectal cancer in Missouri. Patterns and trends among sex, race and age subgroups of the Missouri population in the incidence (1985-1992) and mortality (1980-1996) of the disease are reported. We also compare Missouri colorectal cancer indicators with those estimated for the US (SEER) in order to put the statewide rates into a national context.

Methods

In this study, we analyzed colorectal cancer incidence and mortality rates by sex, race (white and African-American), and age group (<65 and ^{3}65 years of age) for the population of Missouri.

Incidence rates for the years 1985-1992 were provided by the Missouri Cancer Registry (MCR), a population-based registry that has been operational since 1985. The Missouri Center for Health Statistics (MCHS), which collects information from death certificates, provided colorectal cancer mortality rates from 1980 to 1996. Rates were directly standardized to the US 1970 population.

To allow for a comparison between Missouri and US rates, we used the same statistical methods in this analysis as were used by the Surveillance, Epidemiology and End Results (SEER) program.[29] The estimated annual percent change (EAPC) was formulated by calculating the natural logarithm of the rates for each year of the study period and fitting a linear regression line over the logged rates, with year as the independent variable. We then calculated the EAPC by exponentiating the slope ($\beta 1$) of the trendline, subtracting one, then multiplying by one hundred [EAPC = $(e^{\beta 1} - 1) \cdot 100$]. We calculated period percent change (PPC) by subtracting the average of the last two years in the period by the average of the first two years of the period, and dividing the difference by the average of the first two years. The quotient was then multiplied by 100 [PPC= $((\mu_{\text{last 2 years}} - \mu_{\text{first 2 years}}) \div \mu_{\text{first 2 years}})$].

We assessed the EAPCs for statistical significance by testing the null hypothesis of no change in rate ($\beta 1=0$) using the t distribution of $\beta 1 \div SE_{\beta 1}$ for p=.05, with degrees of freedom equal to the number of calendar years in the period minus two.[29] EAPC's and PPC's were calculated for colorectal cancer incidence (1985-1992) and mortality rates (1980-1996, 1980-1990 and 1990-1996) for subgroups of the population by sex, race (white, African-American), and age group (<65, ≥65 years of age).

Results

From 1985 to 1992, Missouri experienced an average annual decrease of 1% (p=.003) in the incidence of colorectal cancer. This trend mainly reflected the decrease in incidence among whites (-1.2% per year, p=.0002), as African Americans did not experience a significant change in rates (0.7% per year, p=.8). Among whites, there was a greater yearly decrease in females (-1.5% per year, p=.0007) than in males (-0.7% per year, p=.05)

Figure 1A. Missouri yearly colorectal cancer incidence rates by race and sex, 1985-1992.

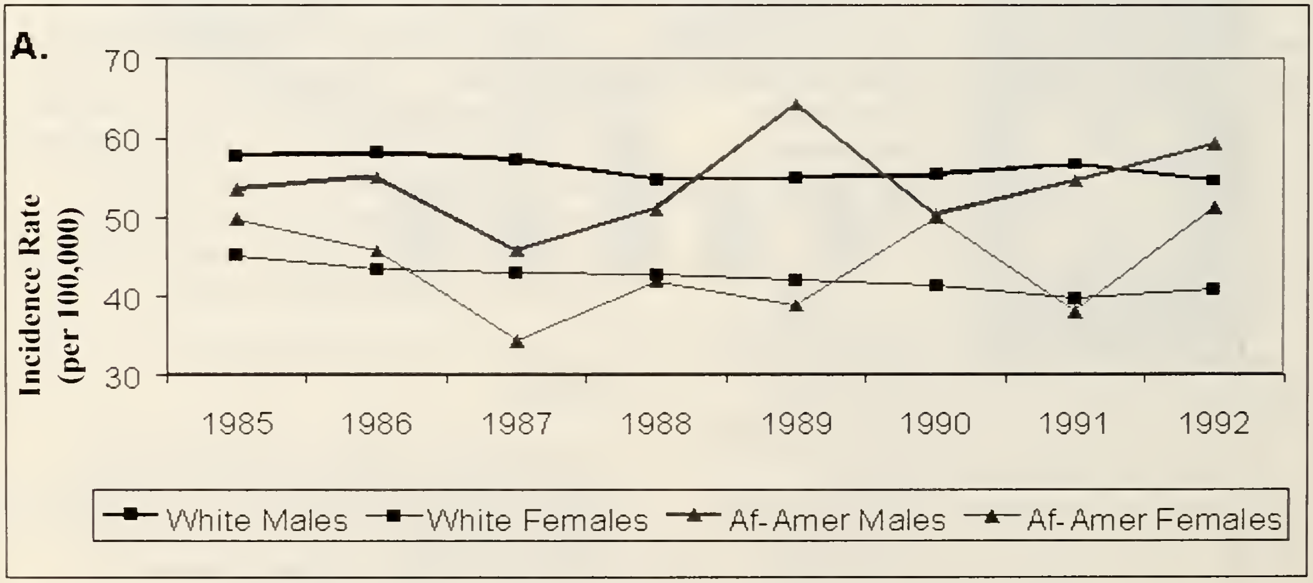
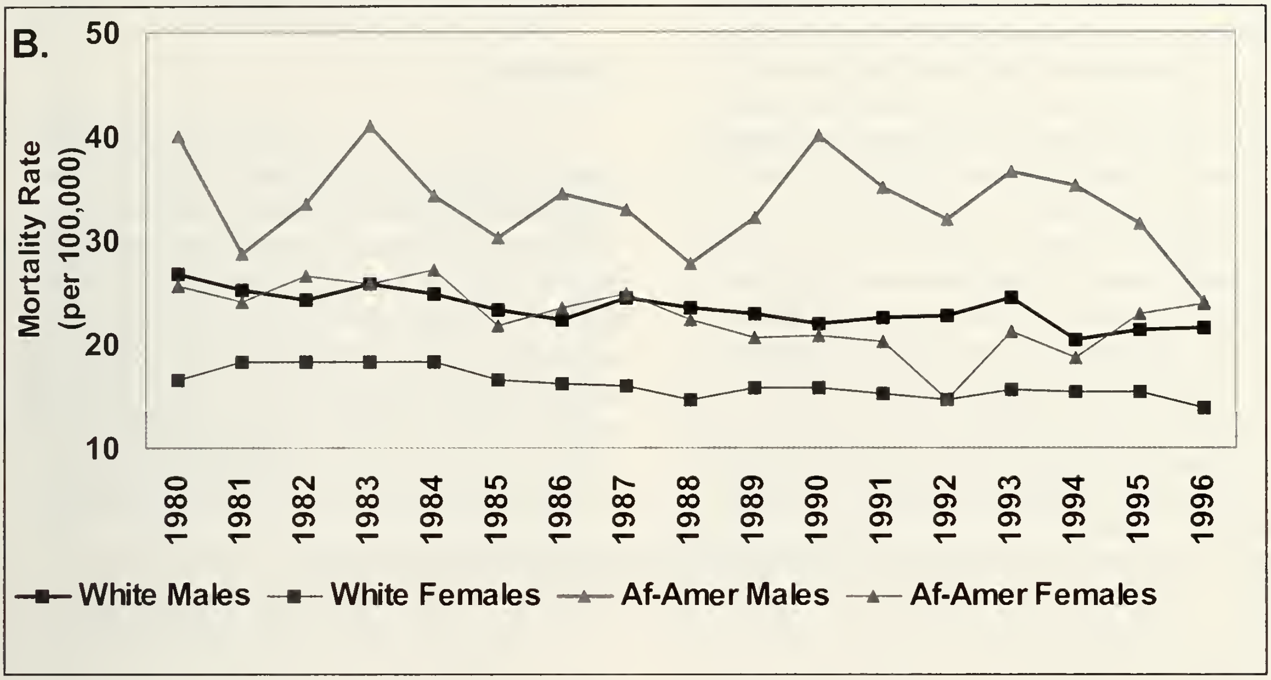


Figure 1B. Missouri yearly colorectal cancer mortality rates by race and sex, 1980-1996.



(Figure 1A). We observed the same trends in Missourians <65 years of age as in the overall population. Among Missourians ≥65 years of age, however, white females were the only subgroup that experienced a significant decrease in incidence (-1.1% per year, p=.003). The most striking observation in the older age group was the significant increase in incidence among African-American males, at almost 5% per year (p=.01).

Although there was a slight racial disparity in incidence trends from 1985 to 1992, there was no difference in the mean incidence rate (47.6 per 100,000) between whites and African Americans. The mean incidence rate in males was about 30% higher than in females, overall and across race. As expected, incidence was highest among Missourians ≥65 years of age; 15.6 times higher than among those <65 years of age and 6.4 times higher than the overall rate.

Between 1980-1996, the overall colorectal cancer mortality rate in Missouri decreased at an average of 1.3% per year (p=.0001). We observed a decrease in every subgroup by sex and race with the exception of African-American males, who experienced no significant change in mortality during that period (Figure 1B). Similar decreasing trends were observed after stratifying the population into age groups (<65 years of age, ≥65 years of age). The average annual decrease was greater in the younger age group (-1.9%, p=.0001) than the older age group (-0.9%, p=.0002). The greatest age disparity in mortality trends was observed in African-American females, who experienced a significant decrease among those <65 years of age (-3.7% per year, p=.0009), but no change among those ≥65 years of age.

We further examined mortality trends by comparing trends between the former (1980-1990) and latter (1990-1996) portions of the overall study period. Mortality rates decreased for almost every subgroup during the former period, but did not change significantly during the latter period. The only exception was African-American males, who did not experience a significant change in mortality during the former period, but whose rates decreased on the average of 5.7% (p=.04) per year during the latter period. After stratifying by age group, we observed additional differences in trends among race and sex subgroups. From 1980 to 1990, African-American females <65 years of age experienced a significant yearly decrease of 5.5% (p=.01), while mortality among those ≥65 years of age did not change. From 1990 to 1996, mortality decreased slightly (-1.6% per year, p=.02) among Missourians <65 years of age, but did not change significantly for those ≥65 years of age.

The mean mortality rate (1990-1996) was about 42% higher among African Americans (25.5 per 100,000) than whites (18.0 per 100,000) in Missouri. Mortality among white males was 46% higher than in white females, while among African Americans, mortality was 64% higher in males than females. As with incidence, the burden of mortality was highest among Missourians ≥65 years of age; 21.1 times higher than among those <65 years of age, and 7.1 times higher than the overall population.

Discussion

In general, Missouri colorectal cancer incidence and mortality rates paralleled those of the US (SEER) over the periods studied (1985-1992 and 1980-1996, respectively).[29,30] US (SEER) incidence rates were generally slightly higher than those of Missouri, although Missouri and US (SEER) rates began to converge during the latter part of the study period (Figure 2A). The overall (all races, sexes and ages combined) estimated annual percent decrease in the incidence of colorectal cancer among Missourians (-1.0% per year) was also observed in

Figure 2A. Missouri and US (SEER) yearly colorectal cancer incidence rates by race, 1985-1992.

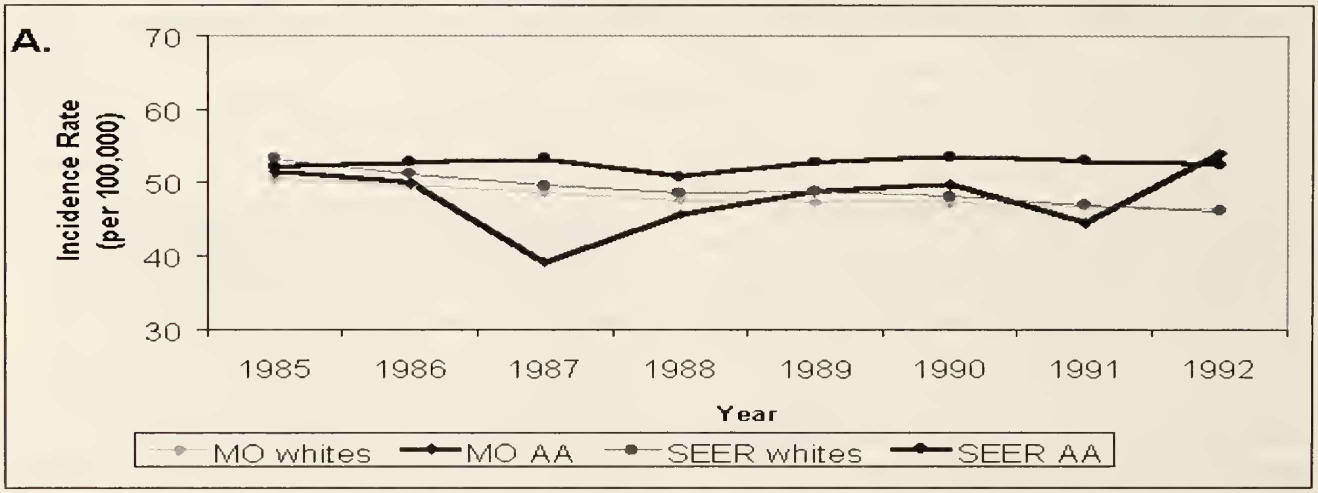
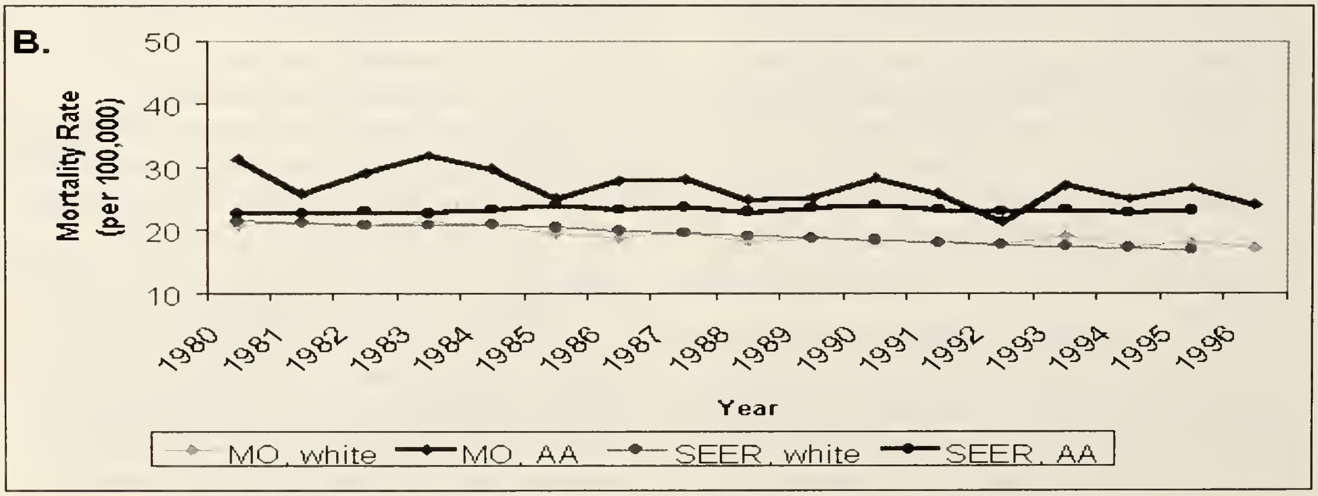


Figure 2B. Missouri and US (SEER) yearly colorectal cancer mortality rates by race, 1980-1996.



US (SEER) rates, to a slightly greater extent (-1.4% per year). While whites experienced a decrease in incidence of colorectal cancer both at the state (-1.2% per year) and national (-1.6% per year) level, we observed no significant change in incidence among African Americans.

Mean incidence rates for study subgroups were similar in Missouri and the US, with the exception of white females, whose rates were slightly higher in Missouri (42.6 per 100,000) than in the US (39.6 per 100,000). The pattern among those <65 years of age was similar to the all-age group. Incidence among those ≥65 years of age was slightly lower in Missouri than in the US among males, while among females there was no difference.

Among whites, mortality decreased nationally (SEER, 1991 to 1995) at the rate of -1.5% per year ($p<.05$), while in Missouri (1990 to 1996) the slight decrease was not statistically significant (-0.8% per year, $p=.2$). The notable decrease in mortality we observed among African-American males in Missouri (-5.7% per year, $p=.04$) was not observed in US rates.

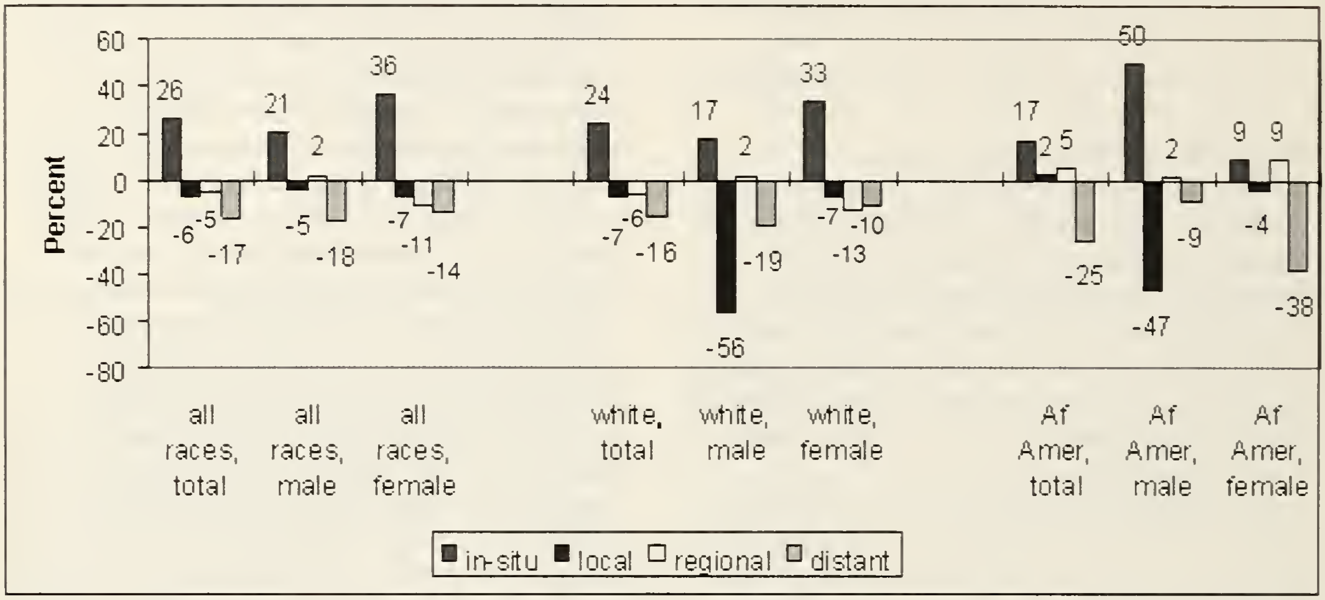
Mortality rates were generally similar in Missouri and the US, with some slight fluctuations over the study period among subgroups (Figure 2B). There were no significant differences between the mean mortality rates of Missouri (1990-1996) and the US (1991-1995) for any subgroups, by race, sex and age, though Missouri rates were consistently slightly higher than US rates.

While this study found an overall decrease in colorectal cancer incidence between 1985 and 1992, results of studies on trends of colorectal cancer risk factors indicate that this decreasing trend may level in coming years among Missourians. A recent statewide study reported predictions of selected major chronic disease risk factors, including indicators such as physical activity and obesity that are related to colorectal cancer risk. The study found that from 1986 to 1995, the prevalence rate of physical activity remained steady around 33%, while the rate of obesity is expected to continue increasing to 35% in the year 2000 and 45% in the year 2010.[31] Another study on fruit and vegetable consumption in Missouri found only a slight increase in daily consumption of fruits and vegetables from 3.4 servings per day in 1990 to 3.5 servings per day in 1994, still far from the recommended 5 servings per day.[32] Likewise, population predictions indicating the proportion of elderly residents in Missouri's population will continue to increase over the next couple decades suggest that colorectal cancer incidence and mortality should not be expected to decrease dramatically in the near future.[33] By the year 2020, it is estimated that 18% of Missouri's population will be comprised of adults over the age of 65, and 25% between the ages of 45 and 64.

Although mortality due to colorectal cancer decreased in Missouri from 1980 to 1996, the absence of a decrease among all subgroups but African-American males between 1990 to 1996 suggests that continued and additional efforts are needed to detect and treat the disease as early and effectively as possible. The increase in the percent of in-situ cases, along with the decrease in percent of distant cases, for all study subgroups (1985 to 1992) is consistent with the expected pattern resulting from increased early detection (Figure 3). In addition, the prevalence of lifetime proctoscopy among Missourians ≥ 50 years of age, corresponding to the recommended screening intervention of the US Preventive Services Task Force, has increased from 32.8% in 1993 to 41.1% in 1997, surpassing the Year 2000 objective of 40% set by Healthy People 2000.[34,35]

This study, as well as other national studies, reports the existence of a racial disparity in the burden of colorectal cancer. Cooper, et al. (1995 and 1997) found that while incidence was greater among whites in the national Medicare population they analyzed, the case-fatality rate of colorectal cancer was greater among African Americans.[36,37] Another study, which examined treatment for colorectal cancer in a national sample of hospitals (20,000 patients), found that African Americans were hospitalized with more advanced stages of the disease in addition to being treated less aggressively than whites.[38] The evidence suggests the existence of a racial disparity in the early detection as well as treatment of colorectal cancer in the US, which is supported by the racial pattern in incidence and mortality rates reported in the Missouri data among all but elderly African-American males.

Figure 3. Stage-specific percent change (1985-1992) in colorectal cancer incidence by race and sex.



Among African-American males in Missouri ≥65 years of age, the dramatic increasing trend in colorectal cancer incidence (27.2% from 1985 to 1992) along with the sharp decrease in mortality (-30.7% from 1990 to 1996) was considerably different from the trends experienced by other race, sex and age subgroups analyzed in this study. This group also experienced the largest percent increase in in-situ cases (50%) as well as a large percent decrease in distant cases (-47%) between 1985 and 1992. This suggests that early detection and treatment efforts may have been reaching this high-risk population, even though the prevalence rates for colorectal cancer screening among African-American men (≥50 years old) in Missouri were not significantly different from those of the rest of the population for the years rates were available.[39,40,41]

This study has several strengths. The incidence data originating from the Missouri Cancer Registry has been evaluated to be around 95% population-based. Mortality rates from the Missouri Center for Health Statistics are also deemed reliable. The methods we used for estimating rates and trends are well established for this type of analysis and published by SEER.[29] One limitation of the study is the possibility of misreporting in both cancer registry and MCHS rates. Although there has been no study specific to cancer reporting in Missouri that has shown this to be true, studies of other chronic diseases demonstrating misreporting suggest the possibility.[42] In addition, the conclusions we could draw in terms of finding explanations for the observed trends and patterns were limited because these data don't allow a causal relationship to be established between the occurrence of the disease with major risk factors for colorectal cancer.

These data are useful for public health programs aimed at reducing the burden of colorectal cancer in Missouri's population. Efforts to promote protective behaviors such as exercise and increased fruit and vegetable consumption for reducing the risk of colorectal cancer should include all segments of the population, and particularly focus on establishing good physical activity and nutrition habits among youth. Programs aimed at increasing early detection of colorectal cancer through promoting and providing screening services should put particular emphasis on targeting African Americans in Missouri in an effort to reduce the disproportionately large burden of mortality in this group. **MoMed**

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Steve M. Gnatz, MD, MHA presented "Future of PM&R Impact of Prospective Payments: The Balanced Budget Amendment" at the American Osteopathic College of Rehabilitation Medicine.

Jon Rupright, DO presented "DVT in Rehabilitation Patterns" at the American Osteopathic College of Rehabilitation Medicine, of which he was the chairman.

Robert Conway, MD, presented "Low Back Pain" at the American Osteopathic Society of PM&R Annual Program.

G. Robert Kletzker, MD, FACS, was installed as President of the Missouri Society of Otolaryngology-Head and Neck Surgery during the annual association meeting.

Lawrence Rues, MD, has been installed as President-Elect of the Missouri Academy of Family Physicians.

In Memoriam

Richard (Gene) Baska, MD, 69, Overland Park, KS, passed away June 3, 1999. Dr. Baska was a retired child neurologist and a member of the Missouri State Medical Association.

Paul Joseph Centner, MD, 78, Prairie Village, KS, passed away July 14, 1999. Dr. Centner was a retired general surgeon and a member of the Missouri State Medical Association.

Waldo "Bill" Forsman, MD, 84, St. Louis, passed away June 21, 1999. Dr. Forsman was a retired internist and a member of the Missouri State Medical Association.

James N. Haddock, MD, 79, Webster Groves, passed away July 12, 1999. Dr. Haddock was a retired psychiatrist and a member of the Missouri State Medical Association.

Warren F. Wilheim, MD, 81, Lake Ozark, passed away June 29, 1999. Dr. Wilheim was a retired internist and a member of the Missouri State Medical Association.

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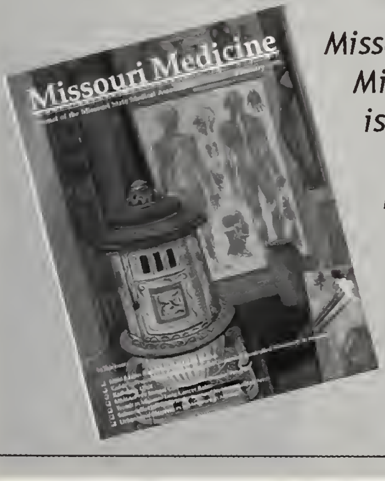

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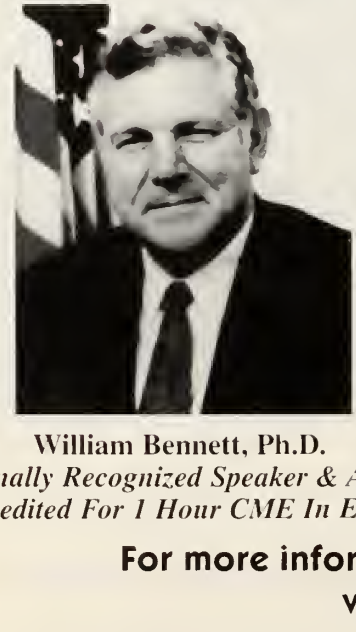

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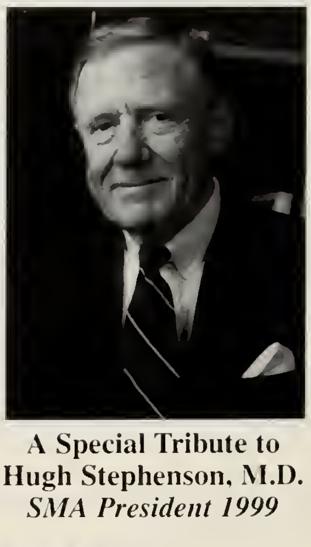

A Special Tribute to
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CME Listing

SEPTEMBER

8 - ***St. Louis:*** **Update on Sleep Disorders.** Call St. John's Mercy Medical Center 314-569-6290.

10- ***St. Louis:*** **10th Annual Ultrasound Conference.** Call St. John's Mercy Medical Center 314-569-6290.

10 - ***Springfield:*** **Pediatric Advanced Life Support Provider Renewal Course.** 5.50 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

11 thru 13 - ***Branson:*** **Optimal Trauma Care: Nightmares in Orthopedic Injuries.** 9 credit hours. Call Carol Osborne 816-932-3737.

13 - ***St. Louis:*** **Radiology: Now and the Future.** 1 credit hour. Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology 314-362-7130.

15 - ***St. Louis:*** **12th Annual Trauma Care Conference.** Call St. John's Mercy Medical Center 314-569-6290.

17 - ***St. Louis:*** **Pharmacotherapy of Sepsis and ARDS.** 5.25 credit hours. Call Washington University 800-325-9862.

17 - ***St. Louis:*** **2nd Annual Missouri Cancer Pain Initiative.** Call Washington University 800-325-9862.

18 - ***St. Louis:*** **Lung Cancer Screening.** 5 credit hours. Call Washington University 800-325-9862.

18 & 19 - ***St. Louis:*** **Surgery for Chronic Ear Disease.** Call Sandy Turk, Practical Anatomy Workshop of St. Louis University 314-535-4000.

24 & 25 - ***Kansas City:*** **Update in Cardiology and Cardiovascular Emergencies.** 13 credit hours. Call Kim McChesney 816-932-5140.

27 thru 29 - ***St. Louis:*** **Sellar & Parasellar Pituitary Tumors.** 15 credit hours. Call Sandy Turck, Practical Anatomy workshop, St. Louis University 314-535-4000.

OCTOBER

1 - ***Kansas City:*** **Laboratory Aspects of Thrombotic and Hemostatic Disorders.** 6 credit hours. Call Kim McChesney 816-932-5140.

1 & 2 - ***Ridgedale:*** **Procedures for Primary Care.** 12 credit hours. Call Kim McChesney 816-932-5140.

1 & 2 - ***Osage Beach:*** **Medical/Pediatric/Ob-Gyn Update for the Primary Care Physician.** 12.5 credit hours. Call Sarah McMullin, St. John's Mercy Hospital 636-239-8218

1 thru 10 - ***St. Louis:*** **Clinical Neuroanatomy, Neurology & Neurosurgery.** 80 credit hours. Call Sandy Turck, Practical Anatomy Workshop, St. Louis University 314-535-4000.

4 - ***St. Louis:*** **Ultrasound Contrast Agents.** Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology 314-362-7130.

7 - ***Springfield:*** **Breast Cancer in the Primary Care Patient: Maximizing the Medical, Minimizing the Legal.** 3.5 credit hours. Call Greene County Medical Society 417-887-1017.

15 - ***Springfield:*** **Pediatric Advanced Life Support Instructor Course.** Call Maryann Jeter 417-885-5400 or 800-835-5201.

16 - ***St. Louis:*** **Best Practice in Primary Care: A Guide for Management of Common Chronic Diseases.** Call Washington University 800-325-9862.

20 - ***St. Louis:*** **14th Annual John V. King Family Symposium.** Call St. John's Mercy Medical Center 314-569-6290.

21 & 22 - ***St. Louis:*** **25th Annual Symposium on Obstetrics and Gynecology.** Call Washington University 800-325-9862.

23 - ***St. Louis:*** **New Techniques in Urinary Incontinence and Female Urology.** 8 credit hours. Call Washington University 800-325-9862.

26-29 - ***St. Louis:*** **The Pterional Approaches.** 32 credit hours. Call Sandy Turck, Practical Anatomy Workshop, St. Louis University 314-535-4000.

28 thru 30 - ***St. Louis:*** **Contemporary Cardiothoracic Surgery.** 18.5 credit hours. Call Washington University 800-325-9862.

28 thru 30 - ***St. Louis:*** **6th Annual Current Topics in Cardiothoracic Anesthesia.** 19 credit hours. Call Washington University 800-325-9862.

NOVEMBER

3 - ***Kansas City:*** **Current Issues in Blood and Marrow Transplantation: Advances in Allogeneic Transplantation.** 2 credit hours. Call Kim McChesney 816-932-5140.

5 & 6 - ***St. Louis:*** **Physician Executive Leadership.** Call Washington University 800-325-9862.

8 - ***St. Louis:*** **Spiral CT for the Diagnosis of Pulmonary Embolism.** Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology 314-362-7130.

12 & 13 - ***St. Louis:*** **Neurosurgical Endoscopy.** 14 credit hours. Call Sandy Turk, Practical Anatomy Workshop St. Louis University 314-535-4000.

12 & 13 - 27th Annual Kilo Diabetes Symposium. Current Topics in Diabetes, Endocrinology and Vascular Disease. Call Beverly Cantoni 314-434-6500.

12 thru 14 - ***Branson:*** **MAFP Fall Conference.** 10+ credit hours. Call 816-941-3939.

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19 & 20 - ***Kansas City:*** **Effective Tobacco Interventions for Patients and Communities.** Call KU Continuing Medical Education 913-588-4488.

20 & 21 - ***Springfield:*** **Pediatric Advanced Life Support.** 16 credit hours. Call Maryann Jeter 417-885-5400 or 800-835-5201.

DECEMBER

2 & 3 - ***Kansas City:*** **The 29th Annual Presentation of the Heart.** 13 credit hours. Call Kim McChesney 816-932-5140.

9 & 10 - ***Kansas City:*** **Fetal Monitoring and Surveillance in Y2K.** 9 credit hours. Call Carol Osborne 816-932-3737.

10 - ***St. Louis:*** **Contemporary Women's Health Issues.** Call Washington University 800-325-9862.

10 thru 12 - ***St. Louis:*** **Craniofacial Surgery and Transfacial Approaches to the Skull Base.** 24 credit hours. Call Sandy Turck, Practical Anatomy Workshop St. Louis University 314-535-4000.

11 - ***St. Louis:*** **Topics in Cardiology.** Call Washington University 800-325-9862.

13 - ***St. Louis:*** **Liver Tumors: New Roles for the Radiologist.** Call R. Gilbert Jost, MD, Mallinckrodt Institute of Radiology 314-362-7130.

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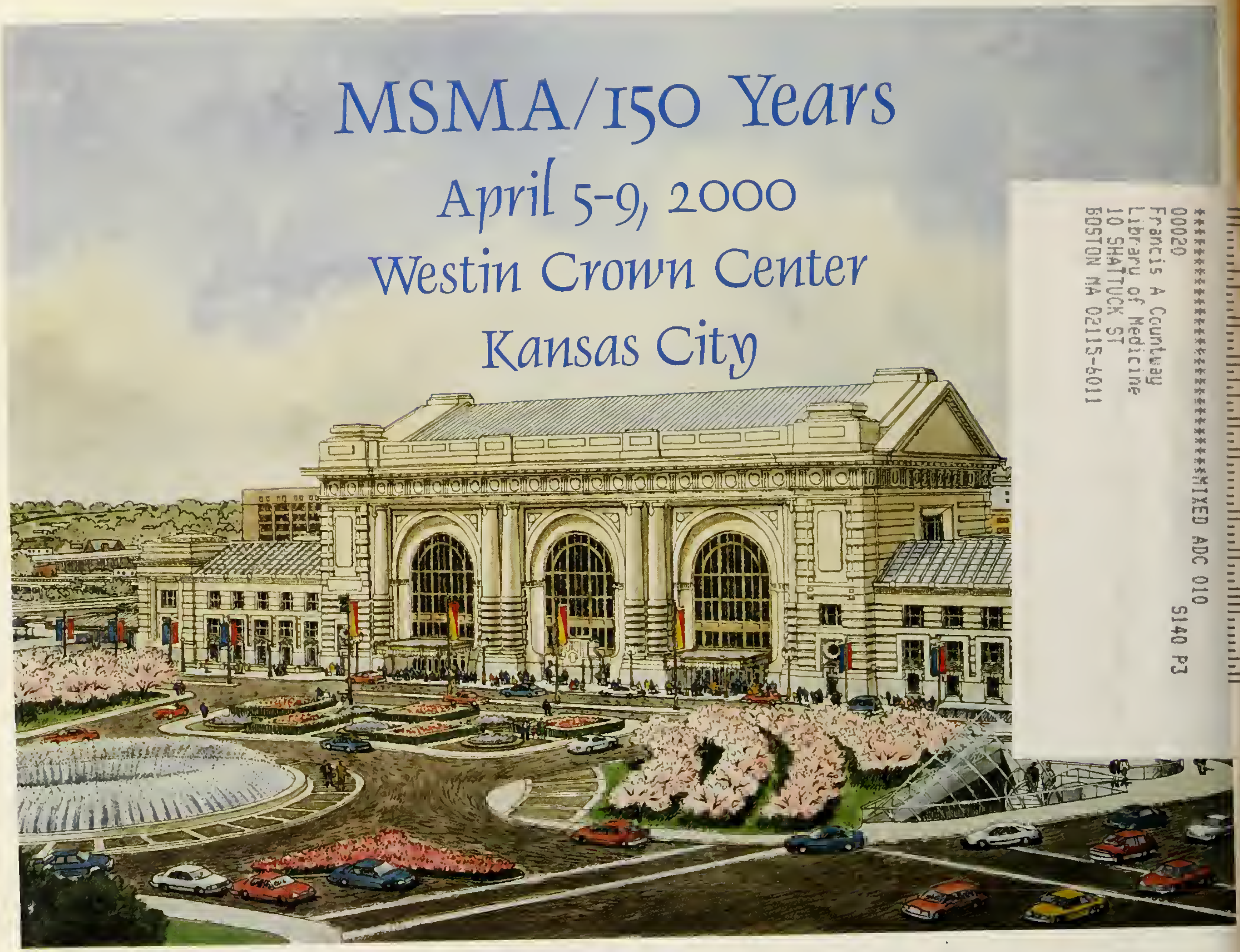

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- Alliance Fall Conference Preregistration
- Toward the Survival of Private Healthcare Delivery
- Radiology Quiz
- The Importance of Mammography
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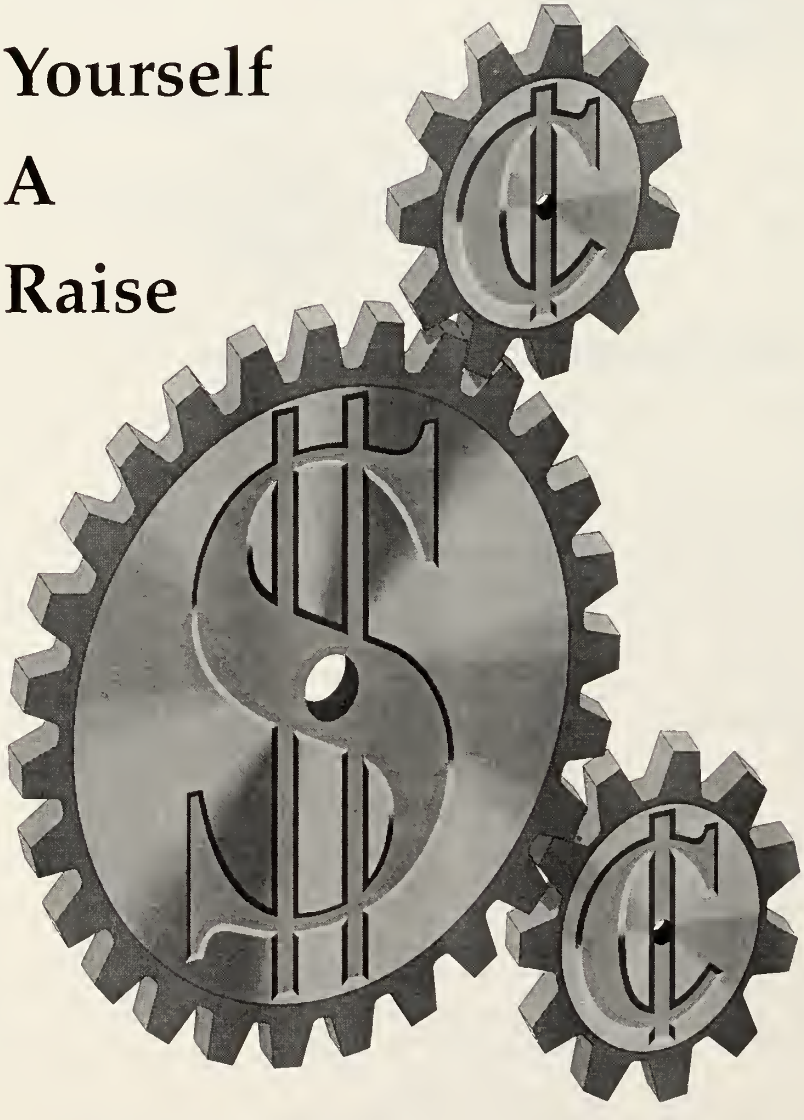

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Editor's Desk

Are You a Leading Physician?

J. Regan Thomas, MD

Are you a "leading physician?" If you are not sure, you may want to check the internet to find out. Just as in recent years there has been controversy related to ranking hospitals based on complication rates or morbidity-mortality rates, there is now concern about how physicians are characterized on internet listings aimed at consumers.

Within organized medicine, the AMA has been attempting to develop what has been characterized as a "seal of approval" for several years through its American Medical Association Program (AMAP). Still in development, it will provide what the AMA feels is a comprehensive overview of individual physician quality indicators. AMAP's board in particular and AMA's leadership in general has had to grapple with concerns ranging from state organizations who do not want to participate at all, to specialty groups who are at odds with non-board certified physicians as to the role to board certification in the listing.

A few states have begun to list physician profiles on data bases provided by the state medical boards but these are limited and not national in scope. Massachusetts for example has designed an internet physician profile service which includes physician training backgrounds, malpractice information and disciplinary actions. They do not however make overt statements about quality in regard to the doctors listed.

At least one group now does that however on the internet. A service highlighted by *AMNews* recently has begun to distinguish what they call "leading" physicians as opposed to those who are not by their criteria. An internet site, http://www.healthgrades.com, has begun in recent months to provide consumer health information including listing physicians. At this point 58% of physicians are included as "leading physicians." Criteria include board certification, practice for at least two years and no Medicare or state licensure problem for at least three years. For some specialties, the physician must be on staff with a hospital which is ranked highly based on another section the same internet service.

Most of the information is already available to interested consumers. The main controversy centers around the implied distinction of "quality." Being a "leading physician" or perhaps more importantly, not being on the list may be in fact misleading argue many of the critics of the program. The proponents argue that although the information is theoretically available, it is often difficult or inconvenient for medical consumers to obtain. The "single click" convenience is what makes the service attractive.

Whether you like the web site or not, it's there. The web site owners project 180,000 users each month on the site. It was inevitable that this would occur probably and no doubt many similar additional sites will spring up. Maybe it's more imperative now that the medical community catch up with the technology and the trends of the present culture and insure there are reliable, credible, convenient information sites. Maybe that is AMAP. If so, it needs to hurry up or be left in the internet "dust." **MoMed**

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Erythema Chronica Migrans, Ticks and Lyme Disease in Missouri

A newly established group called "Emerging Infections of the Central States (EICS), comprised of practitioners throughout the state of Missouri, are completely awed by the incredible assertions Ronald Swinfard, MD, and Philip Anderson, MD, (will be referred to as (S&A) in the content of this letter) have written in their article, "Erythema Chronica Migrans (ECM), Ticks and Lyme Disease in Missouri." We would like to assert that:

•ECM is an acronym for Erythema Chronicum (not Chronica) Migrans and has been supplanted by Erythema Migrans (EM).

•(S&A) implied (EM) has marginal, if any, diagnostic utility and is NOT a marker for any disease. This is rebutted by their own references. They cited 18 references (none supports conclusion) - 2 actually refers to EM as pathognomonic, 4 do not address the clinical diagnosis, 5 are historical references published before spirochetal etiology was discovered, and 6 describe EM as characteristic/ distinctive, useful diagnostic markers.

•Ten modern references reinforce the usefulness of EM as an indicator for Lyme disease, which is opposite Drs. (S&A's) opinion, which states "it is not advisable to treat ECM with antibiotics."

•Not a single reference involving Missouri's clinical experience was used (i.e., published in *Archives of Dermatology*, *Archives of Internal Medicine*, and in the *Journal of Clinical Microbiology*.

•(S&A) state "the causative spirochete together with the tick have been found in only 14 . . . absence in Missouri . . ." We state numerous references referring to *I. Scapularis* and *A. Americanum* in Missouri.

•Stated by (S&A), ". . . Lyme disease does not occur naturally in mid-Missouri . . ." We argue researcher Gregory McDonald, PhD, has molecular evidence from ticks and humans that Lyme disease does in fact exist. Data from spirochetes has an outer surface protein A, different than *B.b.*31 sensu stricto, which places MO spirochetes as *B.b.* sensu lato. Two other studies by the US Army has documented *B.b.* from Missouri ticks.

•(S&A) state 3 references about Lyme seriologies, we state EM is not a laboratory diagnosis, serologies are insensitive and difference *B.b.* strains test different. We are warned to not use serology as an indicator of diagnosing EM when genospecies or strain variations are suspected.

•There is a large number of published Missouri EM photographs, which cannot be confused with chigger bites. Over 80% of EMs have solitary lesions, which are typically painless and minimally pruritic. EM rashes are usually larger, and do not qualify for CDC surveillance definition unless they are 5 cm in diameter.

•Authors state ". . . no knowledge about cutaneous reactions to the bites of sterile ticks which is an essential control group in the proper study of tick bites." Many researchers maintain colonies of sterile ticks used in animal experiments. Sterile ticks have to be fed on animals to maintain the colony. A study between the Texas and Missouri Departments of Health analyzed 165 consecutive imbedded ticks and presented findings at the V Internal Conference in 1992. We are unaware of any published scientists who does not believe that southern EMs are the result of a tick vectored infectious disease.

•(S&A) implied EM was of minimal import and not pathognomonic of any disease. We do not agree. There are a large number of distinguished published researchers who have demonstrated the diagnostic usefulness of EM even though (S&A) describe it as "common, nonspecific, and inconsequential." We do not believe the rash is pathognomonic but agree that it is characteristic and a valuable marker for *borrelia* infections.

•(S&A) present ". . . typical ECM occurred mostly without any spirochetosis . . . " We are unaware of any other published authors who would agree with that incredible, unreferenced declaration.

•Also stated ". . . most states in the US, it is not advisable to treat ECM with antibiotics as if it were lyme borreliosis, without better evidence." With our knowledge, we do not know any other researchers who would recommend not treating EMs. They cite one reference and it recommends treatment. CDC also recommends antibiotic treatment. This astounding declaration is given with no data or references to support their recommendations.

Drs. Swinfard and Anderson ignored all published references to the issue and declared with certainty the absence of Lyme Disease in Missouri.

We believe this pronouncement of Missouri as a "Lyme-free zone" to be both premature and unwarranted. Fortunately, improved technology and current studies should soon resolve the issue. We have thoroughly evaluated the patients and the data, and unlike Drs. Swinfard and Anderson, plan to continue treating EM patients with antibiotics.

This letter is fully endorsed and supported in its entirety by Emerging Infections of the Central States (EICS).

A list of references may be obtained by contacting Karen Iadanza, Executive Secretary, at 573-882-3107.

Drs. Swinfard and Anderson have provided us with an interesting review of the early uses of the term Erythema Chronica Migrans in the first two decades of the century. One could wish they had explained the transition from ECM standing for Erythema Chronic Migrans in 1920 to the ECM standing for Erythema Chronicum Migrans in the four articles from the 1960s (their references 6-9). It is not clear how Pollitzer in the 1920 Darier textbook could have pointed out the experiences of dermatologists publishing in the 1960s. Nor is it clear who the authors may be alluding to in their unreferenced uses of "No one . . .", ". . . they knew . . .", or ". . . they were well aware . . . ". They point out that the term ECM came to be associated with Lyme disease but give no indication that the term Erythema Migrans or EM has become the accepted designation for the rash phase of the illness.

There is a profound poignancy in their admission that ". . . we have continued to see many such cases of ECM from tick bites regularly over the last 36 years, still none with Lyme Borreliosis." Herein lies the enigma of Lymne disease or Lyme-like disease in Missouri about which I wrote in this journal in 1992. We continue to hear of physicians who see the EM lesions but without laboratory proof do not consider these patients to have Lyme disease. Others do consider these as Lyme disease or Lyme-like disease and report them to the Missouri Department of Health. Some physicians consider these patients to have presumptive spirochetal infections and treat them accordingly. The Swinfard and Anderson advice to the effect that these lesions ought not to be treated with antibiotics is thus controversial.

The evidence continues to mount and to point to Borrelia infection in humans, mammals, and various tick species in the southeastern and southern regions of the US. James Oliver, PhD, of Georgia Southern University at Statesboro, lectured at the University of Missouri on April 8, 1999 where he presented an overview of tick-borne borreliosis in "non-Lyme-endemic" areas of the country. He has 42 strains of *Borrelia burgdorferi* sensu lato isolated from Missouri ticks growing in his laboratory. He indicated that there are more genetic variants of *B. burgdorferi* in southern and southeastern states than in the northern states. He has hypothesized that the *B. burgdorferi* sensu stricto of Lyme disease may have been carried north in the remote past by migratory birds and that the strain(s) carried north may be somewhat more pathogenic than the southern strains.

The enigma is not resolved but researchers are making some progress. I have recently joined several others who are in the process of forming a group called Emerging Infections in the Central States (EICS). We are hoping to encourage the study of patients with Lyme-like disease using standardized protocols, to study the efficacy of the new Lyme vaccine in this part of the country, and to facilitate studies of other emerging infections such as ehrlichiosis and babesiosis. It is regrettable that the Swinfard and Anderson article will add to the confusion and controversy and may serve to discourage rather than to encourage the type of research that will ultimately resolve this enigma.

H. Denny Donnell, Jr., MD, MPH
State Epidemiologist
Missouri Department of Health
Jefferson City, Missouri

A list of references may be obtained by contacting H. Denny Donnell, Jr., MD, at 573-751-6400.

In Response:

We appreciate the interest shown by this group of scientists. Paradoxically, one point in our writing this paper was to deflect some of the attacks, which have been launched against some members of this group. Specifically, that while ECM following tick bites in some geographic areas may not be *Borrelia burgdorferi* infection, (hence, not truly Lyme disease) it may represent another borreliosis which evokes ECM. Then, by extension, reminding readers that ECM (like urticaria and other figurata erythemas) is not a correlate of a single infecting organism. ECM is a cutaneous reaction pattern but, unfortunately for clinicians, there are few such patterns that have one-to-one associations with specific infections, medications, internal disease states, or cutaneous injuries. This is why treating cutaneous reaction patterns rather than demonstrated specific diseases would result in overtreatment and, in some cases, mistreatment.

Ronald W. Swinfard, MD
Chairman, Department of Internal Medicine
University of Missouri-Columbia

Teaching Students Managed Care

Physicians practicing today are not prepared for the changes we faced when managed care came into the picture during the 80s.

While some medical schools are not adequately preparing their students, the University of Missouri Medical School is making sure the physicians it trains are prepared for the future.

At the MU School of Medicine we are not just teaching students about HMOs and capitation, we are teaching them how to provide the highest quality of care, cost effectively. The training includes understanding the health care delivery system, care management, quality assurance, practice guidelines, disease management, population-based medicine, clinical epidemiology, prevention, and ethics.

First- and second-year students have already been exposed to these concepts in their problem-based learning (PBL) and introduction to patient care (IPC) sequences. Starting in June 1999, all third-year students will be involved in a continuity ambulatory experience, with residents and faculty within their primary care clerkships. A small group of third-year students will take part in a pilot case management project where they will follow three patients throughout the year. They will work with preceptors and MissouriCare, the University's Medicaid managed care program, to develop risk assessment tools and case management plans for their patients. Hopefully by June 2000 all third-year students will take part in the case management project. Selected fourth-year students will participate in a pilot elective working with MissouriCare on population-based problems.

In the December 1997 issue of *Academic Medicine*, the Association of American Medical Colleges reported, "Only about a half of medical school graduates feel that enough curricular time is devoted to quality assurance, risk management, and cost control." By making these changes to the curriculum, University of Missouri Medical School graduates will have the skills they need when they begin practicing their chosen profession.

Recently the school has come under fire for teaching students about managed care. Managed care is a fact of life, and we hope to have our graduates understand the concepts of managed care, both good and bad. As academic physicians, we have an obligation to provide our students with the tools they need to practice medicine, and prepare for leadership in organized medicine in Missouri in the future.

Ted Groshong, MD,
Interim Chair, University of Missouri - Columbia School of Medicine

(Letter edited for content)

Editor's note: Jerry Kennett, MD, MSMA's 5th District Councilor, represents MSMA on the Steering Committee.

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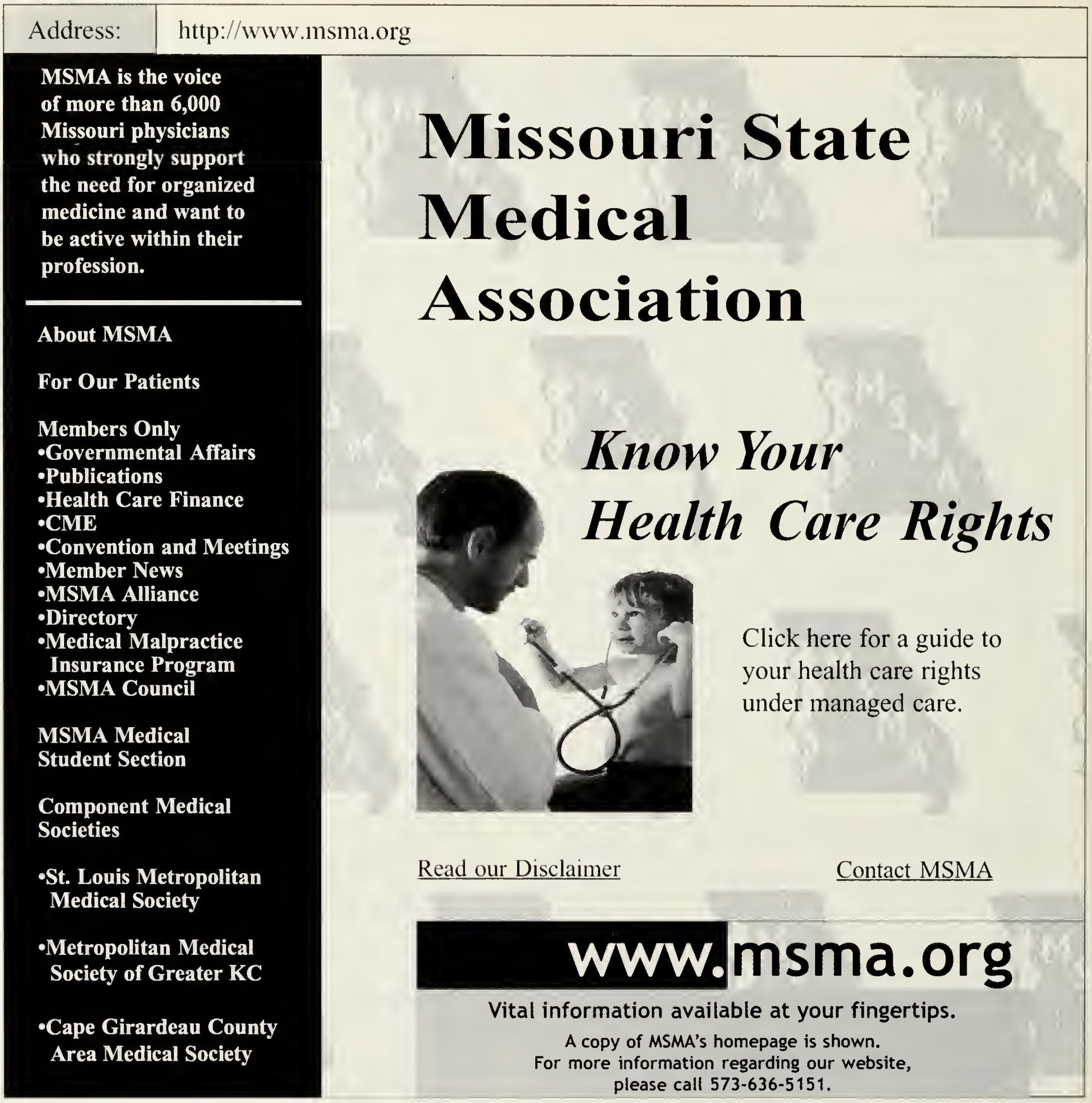

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President's Page

Why Didn't I Think of That?

William Dorzab, MD

When I first heard AMA Executive Vice President, Andy Anderson, MD, use the phrase, "Is it good medicine?" in a speech, I thought, now there's a catchy tidbit some speech writer pulled out of the blue. It did get my attention, but it seemed trite.

As time has gone on I have been very impressed with the power of that simple concept (are not the most powerful concepts often deceptively simple at first glance?). The public debate on myriad patient care questions begs for a simple, catchy "hook" that has the power to galvanize physician and patient understanding of the issues. The phrase "Is it good medicine?" finds broad applicability in wide-ranging discussions and debates.

Of all the parties to the many health care debates only the medical profession is compelled by the ethical mandate to provide good medicine to each patient.

Governments work through a political process. Compromise is the fundamental tool of politics. Good medical care for citizens covered by governmental medical programs can have their "Good Medicine" bargained away in favor of road construction, national defense or any other function of government. Good medical care for beneficiaries of for-profit insurance company plans normally take second place behind maximizing profits to shareholders. Oddly, this is the way it should be, since the boards and managements of such companies have a legal, fiduciary responsibility to shareholders, and to no one else. If patients in such plans are to recieve what they need, outside pressure must be constantly applied.

Organized medicine is the "purest play" for medical ethics in our society. It must drive the debate by repeatedly asking the fundamental question. A question that has more to do with asserting the authority of the medical profession in the health care debate than with becoming immediately preoccupied with winning it on every front. *Is it good medicine?*

Whenever significant comment-ary is at issue, organized medicine should step up with the question: *Is it good medicine?*

When managed care plans restrict the authority of physicians to lead the care of their patients, organized medicine must ask: *Is it good medicine?*

When physicians are forced to see more and more patients and offer less and less time to each one, organized medicine must ask: *Is it good medicine?*

Medical ethics demand that the managed care debate must be waged by putting all health care discussions in the proper context. Determination of who can be trusted to decide the innumerable individual medical decisions that must be made on millions of individual patients in our system of medical care delivery each day must return medical decision authority to the physician and patient in the examination room.

Ironically, the phrase, "Is it good medicine?", derives its potency from the sad, but inescapable fact that most everyone in today's debate over health care policy appears to have forgotten to ask it. Hats off to Andy Anderson for focusing the responsibility on organized medicine. Our patients can only depend upon their physicians and the organizations physicians create and maintain, according to the principles of medical ethics, to fight for the "good medicine" patients deserve and always to ask: *Is it good medicine?*

MSMA has joined with the AMA in the "Is it good medicine?" campaign by sending out letters to the editor to all the weekly and daily newspapers in Missouri. This campaign dovetails with MSMA's health care rights campaign, a statewide educational project encouraging patients and physicians to know their health care rights. MoMed

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Dinner Series to Incorporate EPEC Project

Joni Scott, MD

The Young Physicians Section is launching a Dinner Series statewide beginning in Springfield. After reviewing response cards sent in from young physicians and several discussions with Section members, we will rotate the Series throughout Missouri as component medical societies show interest. These dinner programs will serve not only to increase the visibility of the Section, but also to provide participants with continuing medical education on timely medical topics.

The first Series will incorporate aspects of the EPEC (Education for Physicians on End-of-Life Care) Project. Beginning in 1996, with a gathering body of evidence that physicians were not meeting the needs of patients and their families at the end of life, the American Medical Association began to identify where problems existed through a series of focus groups, surveys, and other research techniques. It was apparent there was a huge gap in the educational and experiential resources that physicians brought to the care of patients at the end of life, especially when that end was the result of a chronic, life-threatening process. This concern took on even greater significance with it was realized that only 10% of patients today die of an acute, short term illness or injury, and the other 90% die of progressive and longer term processes such as cancer, heart and peripheral vascular disease, stroke, diabetes and its complications, chronic renal and pulmonary failure, Alzheimer's and other dementia.

A key finding - that there was essentially no medical school or graduate medical education curriculum or emphasis placed upon the entire subject and support of end-of-life care - led the AMA to establish the EPEC Project. This effort is funded both by the AMA and by a grant from the Robert Wood Johnson Foundation. A team of researchers and educators convened and the result of their work is the EPEC curriculum and program here discussed.

The program designed is a "train the trainer" model with the expectation that this will be the most effective method of transmitting the information to an ever-increasing number of practicing physicians. Over the past year or so, five "train the trainer" sessions have been held, resulting in approximately 400 physicians trained and ready to teach this material to their peers across the nation. Several medical schools are already using EPEC materials in their curriculum and the American Board of Internal Medicine has now made end-of-life care a required core competency. EPEC teaching materials are being developed for program directors in internal medicine.

In Missouri, there are five "EPEC trained" trainers or teachers who can be accessed through the Missouri State Medical Association.

The EPEC program is divided into sections for teaching purposes. Each section (general/plenary session or topic-specific module) can be taught as a stand-alone subject, or together in a series. There are four general sessions and 12 modules; each one of which takes about one hour to present. This curriculum design provides for a maximum amount of flexibility in planning educational programs as each individual session forms a coherent whole and the order of presentation is not critical. The ideal scenario would be for the sponsoring entity to decide to present the entire course in the recommended sequence, over a time period that best meets its needs.

The four plenary/general sessions are the following: gaps in end-of-life care; legal issues in end-of-life care; elements and models of end-of-life care; and next steps.

The twelve modules are: advanced care planning; communicating bad news, whole patient assessment; pain management - in three parts; physician assisted suicide; anxiety, delirium, depression; goals of care, sudden illness; medical futility; common physical symptoms; withholding, withdrawing treatment; and last hours of living - in three parts.

As can be seen, the subjects are wide-ranging and comprehensive which reflect many aspects of our medical responsibility.

For further information regarding the EPEC Project or to schedule an EPEC program contact Ron Ellison, MSMA staff, (tele) 573-636-5151, (fax) 573-636-8552, (e-mail) rellison@msma.org.

Thank you to all young physicians who took time to fill out the response cards. We will try to incorporate many of your ideas into future meetings.

◆ Winners of the Barnes and Noble gift certificates: Drs. D. Shawn Parker, Cape Girardeau; Rebecca Kelly, Columbia; and Thanh Slavek, West Plains. Certificates will be mailed in the near future.

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VIP Reception: We are guests at a reception sponsored by HealthSouth in connection with their ***"Go For It! Roadshow"*** at Cape Girardeau's Show-Me Center. Meet at 5:30 p.m. in the Drury Lodge lobby for transportation to the reception and then to Celebrations Restaurant.

Dutch Dinner: The registration fee of $35 does not include dinner at Celebrations on Tuesday. Price will be determined by your order. Transportation provided.

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Tuesday, October 19	
1:00-4:00 p.m.	Registration
2:30-4:00 p.m.	Board Meeting
5:30 p.m.	Meet in Lodge Lobby
6:00-7:00 p.m.	VIP Reception
7:30-9:30 p.m.	Dutch Treat Dinner at Celebrations Restaurant
Wednesday, October 20	
6:00-8:30 a.m.	Complimentary Breakfast
7:00-8:30 a.m.	Registration & Display Setups
8:30 a.m-2:30 p.m.	AMA Foundation Boutique Shopping
8:30-9:30 a.m.	Welcome & State Officers
9:35-11:00 a.m.	"Go for It!" - HealthSouth Roadshow
11:00 a.m.	Return to Drury Lodge
11:30-12:30 p.m.	Judy Domescik, AMAA Field Director
12:30-1:30 p.m.	Conference Luncheon
1:30-3:45 p.m.	Judy Domescik, Violence Workshop "Let's Help Missouri Stop Violence Everywhere!"
3:45 p.m.	Closing Comments

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Toward the Survival of Private Healthcare Delivery

Christopher Y. Thomas, Jr., MD

Premise: a major cause of the rising real cost of healthcare is the lack of coordinated management. The task of the delivery of care falls onto three autonomous systems: hospitals, physicians, and insurers. If all of these entities were interdependent subsystems within an encompassing task system, the redundancies and duplications, which impair progress and efficiency, could be modified or eliminated. The establishment of internal and external feedback mechanisms, seriously lacking at present, would improve function and allow adaptation to the present accelerating changes in the healthcare environment.

Specialization of medicine blossomed immediately after World War II. It resulted in remarkable progress in medical care. Adam Smith, in Wealth of Nations, book 1, chapter 1, Of the Division of Labor, has the oft-quoted example of the pin maker. By the division of the tasks involved in making a pin into eighteen separate specialties, 48,000 pins could be created in one day. A single person, not well trained in each step, could turn out only 10 pins per day.

The process of specialization has given rise to pluralism. Peter Drucker[1] speaks of pluralism with reference to universities and hospitals. The return of pluralism began between 1860 and 1870. The first organization to emerge was the new business enterprise. It was followed in rapid order by a horde of other new institutions. Each of these institutions is a "special interest" and, Drucker says, "not one of them is concerned with the common good." The pluralistic institutions of a 100 years ago — knights in armor, free cities and merchants guilds — were based on property and power. Today's autonomous organizations — business enterprises, labor unions, hospitals, and universities — are based on function. Within the hospitals, of course, is another whole tree of specializations.

The expense of the advances in medicine became a burden to the average citizen and more and more people became medically indigent. Even though the physicians volunteered time at various clinics and hospitals, it still did not compensate for the total cost. The hospitals had to bear the additional cost of the use of materials and machines. The overall result effectively limited care to a good portion of the public.

First came a partial solution in BlueCross BlueShield in 1938, followed by a private insurance. Then came the revolution — Medicare - in 1966. Suddenly, hospitals were running in the black and were a magnet to increasing numbers of administrative and technical people. With the government now footing much of the bill, there was an explosion of administrative, nursing and medical specialty services requiring funding. No one could ever have imagined the progressive entrepreneurial niches that were created. The "good times" really rolled. At present the resulting decentralization, or pluralism, of healthcare has become costly and inefficient.

Any attempt to amalgamate the hospital, insurers and medicine has to be similar to what Alfred P. Sloan faced at General Motors.[2] In 1920 and 1921, two types of operating problems existed, one arising from too much centralization (duPont) and the other from too much decentralization (General Motors). General Motors was facing an economic slump. By November 1920, all major car-producing divisions, except Buick and Cadillac, had virtually shut down their plants and the others were operating at reduced rates. The whole economy of the United States fell into a slump. William C. Durant, the president of General Motors, resigned on November 30th, 1920.

As a member of the executive committee, and a right-hand man to Pierre S. duPont the new president, Alfred P. Sloan submitted his "Organizational Study." He was struck by the disparity between substance and form: plenty of substance with little form.

Sloan called his plan "coordinated decentralization" and his reorganization remains a classic for students of business. He considered two principles essential: 1) the responsibility attached to the chief executive of each operation shall in no way be limited and, 2) certain central organizational functions are absolutely essential to the logical development and proper control of the Corporation's activities. Using Sloan's plan, General Motors became the largest industrial complex in the world.

Charles C. Lindstrom, recently retired CEO of St. Luke's Hospital in Kansas City, says that, in addition, planners must realize that there was a paradigm shift in health care. What was once a social model became an economic model. This insight changes the focus of discussion.

A paradigm is "a pattern or map for understanding and explaining certain aspects of reality." Stephen Covey[3] says that if you wish to become more effective you can make slow, incremental improvement by changing your attitude or changing your behavior. If you want dramatic, revolutionary, transforming improvement, change your paradigm.

Covey classifies paradigms as scientific, human relations, human resource and principle-centered. In Lindstrom's example, the health-care delivery system moved from a human relations paradigm to the scientific-authoritarian paradigm. Covey says that the need of the scientific paradigm is economic while that of the human relations is social/emotional.

As an example, applying the economic model to the problem of overcapacity is interesting. The overcapacity applies not only to institutions, but also to certain varieties of practitioners and other personnel. Under an economic model, a number of these should be allowed to fail. These fossils and redundancies remain in business, however, for social and political reasons. They are sucking up the healthcare dollars and are contributing to the insolvency of the other institutions.

As costs continued to rise sharply, hospitals began an attempt at both vertical and horizontal integration. Vertical management centered in the hospital. Vertical management of hospitals went from domiciliary care, to nurse training, to medical laboratories, to radiology, to the hiring of physicians and to HMOs. These attempts at vertical integration, especially through such mechanisms as HMOs, looked promising at first but are now failing to control costs. Why would all three of the individual entities of hospital, insurance companies and physicians try to organize HMOs? This seems similar to the redundancy encountered by Sloan at General Motors.

Hospitals are now extending their horizontal management by mergers, acquisitions and joint ventures with physicians. Horizontal integration is aimed at maximization of reimbursement and offers little advantage to the patient.

All entities must deal with the impact of the disabling effect of both specialization and attempted integration. Adam Smith, in book 5, article II "At the Expense of the Institutions for the Education of Youth" says that "the man whose whole life is spent performing a few simple operations.... having no occasion to exert his understanding or exercise his invention.... naturally loses, therefore, the habit of such exertion and gradually becomes as stupid and ignorant as it is possible for a human creature to become... his dexterity at his own particular trade seems, in this manner, to be acquired at the expense of his intellectual, social and martial values."

Peter Drucker adds that "this new pluralism threatens to destroy the capacity to make policy and with it, social cohesion altogether. The challenge is to preserve the autonomy of our institutions.... while at the same time restoring the unity of the polity we have all but lost.... so far no one yet knows how to do it."

The disabling effect of the attempts at integration is the loss of autonomy by all sectors of the health-care delivery system. The impact on the physician is pronounced. The irony is that his opposition to socialization of medicine led to corporatization of medicine and has resulted in the same loss of autonomy that the physician feared. Corporations are now considering a program of behavior modification for physicians to help them accept the new outlook. The restraints of the ideals of professionalism and volunteerism are growing progressively weaker.

All in all, specialization, pluralism and forced integration have consumed all the institutions that are the components of the health-care delivery system. Together they are a system whose coordinated task is the delivery of care to the patient. The present task system is focused in the hospital. The system is being partially centralized in terms of finance, but is being progressively decentralized in terms of service. More and more therapeutic and diagnostic services are moving out of the hospital complex in an effort to reduce overhead costs.

The magnitude of the various changes is threatening to overpower the management of the components of the care system. The job of a hospital board is to govern assets through policy and procedure and expect, if not demand, accountability. Most board members of American not-for-profit hospitals work diligently for a few hours each month. Some few devote a significant portion of their time to building and grounds and the budget —— but few have the time, and do not receive the necessary rewards, to become involved in sorting out the real and emerging problems of not only the hospital but also the entire system.

At present, hospital management carefully filters and condenses the information that the board receives. As a result, much of the chaos and the problems without ready solutions do not come to their attention. Ultimately, this begets failed information systems, failing accounting departments and the unexpected political problems, which are ultimately identified by governments and by the community. Weisbord, et al [4] developed a questionnaire for a major hospital to be used to study methods of cost containment and quality care. It consisted of 60 questions and was sent to all hospital departments. The response of the trustees was notable in at least one respect: the very high proportion of "don't know" answers.

The healthcare delivery system is composed of three autonomous entities —— hospitals with their nursing staff, physicians and insurance companies. The mission of the system should be patient care. Each entity has a specific role or function. Their *task interdependency* is an issue that must be addressed. Covey refers to the **interdependent paradigm**. It includes interpersonal and organizational interdependence. He says that switching from an independent to an interdependent paradigm creates a whole new way of "seeing." It impacts the decisions we make concerning the best use of our time. It literally redefines "importance." It changes doing it yourself to empowering others. It changes supervision and control into facilitating creativity in others. It changes time spent problem-solving conflicting expectations to clarifying them up front. It eliminates time spent solving communication problems by making effective communication possible.

In the recent past, consultants in organizational development tried to design a command and control system for medical centers. They never quite succeeded. They reported that the most difficult obstacle was physician attendance at group meetings. Physicians seemed "too busy." At present, there are two factors that might motivate physicians: loss of autonomy and diminishing income. Ideally, a new committee composed of representatives of all entities should address the construction of an overall operating strategy for the system much as Sloan did at General Motors. Perhaps the committee should include a social scientist and an organizational developer. Its initial duty is to plan data collection and feedback procedures. They would design a questionnaire related to cost containment, i.e. admissions, discharges, tests and procedures, orders and consultations, and cost awareness. In the early going they should not get bogged down in departmental issues. They would then feed back the data to administration, nursing, medical staff and the insurance companies. Next, they would plan systematic feedback and problem solving sessions with all interested groups. If outcome audits can be linked to task system decisions, and not just to physician competence, it could be a step toward connecting standards, good or bad, to dollars, space and staffing decisions. As the second duty they would suggest a guide for the restoration of the autonomy of each operating unit.

Then, the three subsystems of equal status, having continuous dialogue, decide on how to proceed in an ever-changing environment. They should study how to improve the quality of the system output. Through dialogue, the synergy that results causes a continuing self-reorganization of the larger task system.

The present health care delivery system is struggling. HMOs have failed to contain costs and are losing momentum. Uneasiness pervades the whole system. Finger pointing is ubiquitous. Some have lost sight of the original objectives. The present system needs to be reformed. It should be a new plan, based on private enterprise, where the different institutions function independently and have command over their own functions, but are guided by a separate command system. It would seem that Sloan's method would be applicable to individual care delivery systems. It will take different forms in public hospitals, private hospitals and university hospitals, but the basic framework will be the same.

Peter Drucker [5] speaks of "convergence." By this he means the factors that come together to force a paradigm change. The overriding factor nowadays is the march of consumerism led by the baby boomers. They comprise 75 percent of the workforce. Dent[6] points out that they are now 45 years of age and moving into command positions. They are concerned about their health and their children. They are highly individualistic, self-help-oriented, conscious of health and the environment, and quality conscious. They value passion, care and the personal touch. They prefer self or home diagnostic products and services and they want to make their own decisions.

Additional factors that have a bearing on the healthcare management system are: the Internet which empowers people to engage in varying degrees of selfcare; the rise of alternative medicine; the steady increase in the number of uninsured; specialization and the resultant pluralism; and the decentralization of facilities.

Whether the physician can moderate his perceived individual uniqueness and the insurance companies and the hospitals can bend their command and control systems to utilize Sloan's plan toward the goal of cost containment seems to be a tall order. On the other hand, if they continue on the present path, they will have a system imposed on them by external forces - a classic double bind! It is conceivable that major medical clinics could come close to achievement of the plan, and could set the model for others to follow. MoMed

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Radiology Quiz

Roger A. Francis, MD, FACR
Diagnostic Imaging Department
Nevada Regional Medical Center

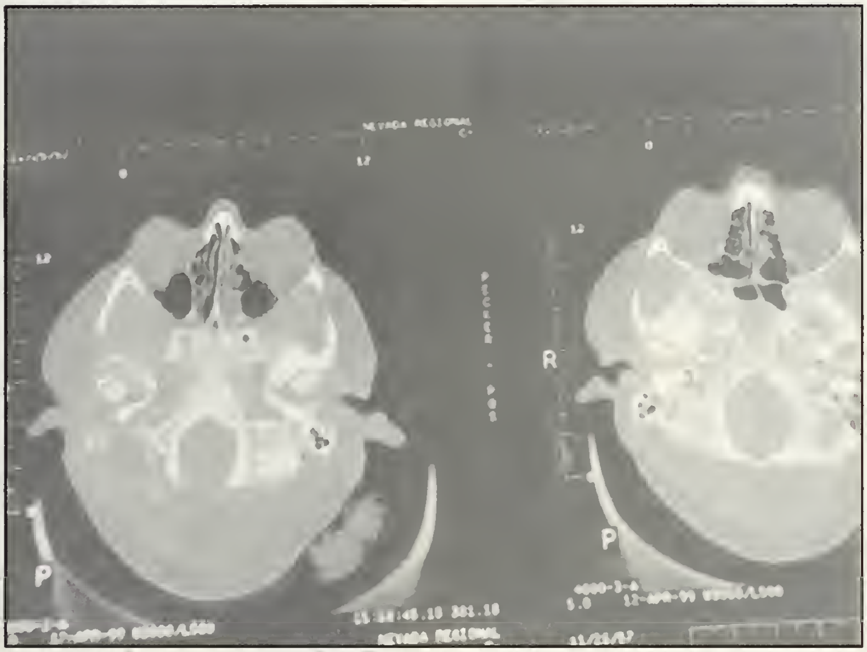

Figure 1

A 41-year-old female was thrown 50 feet from a motorcycle, cracking her helmet. On arrival in the emergency room, the patient was alert, but complained of nausea. The neurologic exam was normal, and the physical was otherwise normal except for ecchymosis about the right ear. As part of the workup, a non-contrast head C.T. scan was performed, with selected slices through the skull base (Figure 1).

What is the most likely diagnosis

- **a. Le Forte III facial injury**
- **b. Basilar skull fracture**
- **c. Subdural hematoma**
- **d. Orbital blowout fracture**

(See answer on next page.)

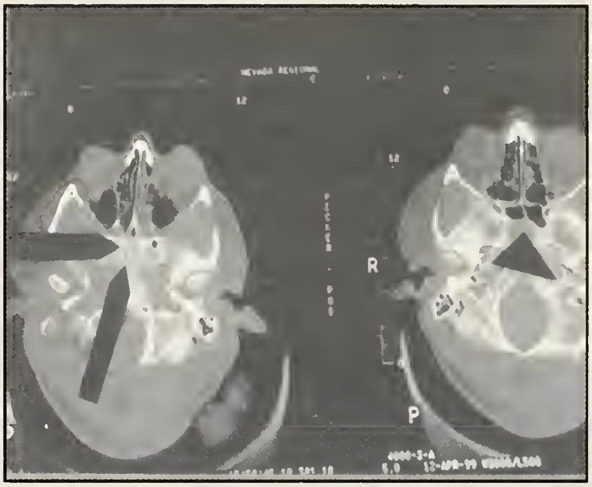

Figure 1 repeated

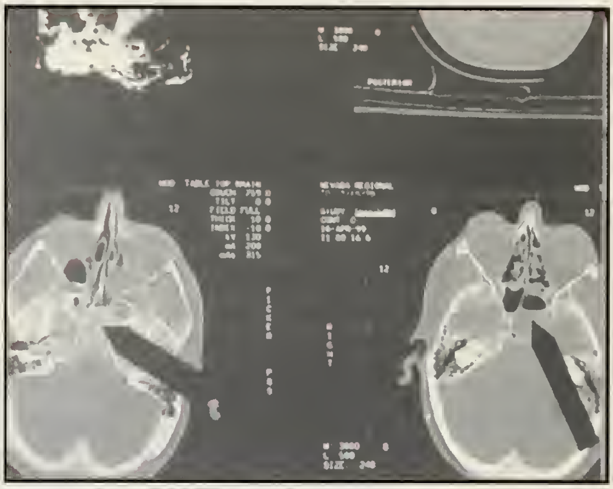

Figure 2

ANSWER

b - Basilar skull fracture

The left image shows multiple fracture lines through the basisphenoid (left arrow, repeat Figure 1). There is also an air-fluid level in the sphenoid sinus (arrowhead in right image). These findings indicate a basilar skull fracture (option B is the correct response).

Fractures of the skull base are fairly uncommon injuries which may be overlooked due to subtle radiographic findings and the presence of accompanying injuries. Due to the strength and thickness of the basicranium, the presence of these fractures usually indicates substantial forces such as from motor vehicle accidents or falls from a height. They are usually associated with other skull or facial fractures.

Clinical findings at presentation vary depending upon location of fracture.

Ecchymosis of the mastoid region (Battle's sign) or the periorbital region (raccoon eyes) are commonly seen. Hemotympanum may result from temporal bone fracture. Fractures through the sphenoid or ethmoid sinus may result in CSF rhinorrhea. Fractures through the central skull base may involve foramina, resulting in cranial nerve deficits or injury to the carotid artery or cavernous sinus which may be life threatening.

Plain radiographs of the skull commonly are normal in basilar skull fracture, but suggestive findings include pneumocephalus or air-fluid levels in the sphenoid sinus on horizontal beam lateral views.

The C.T. scan of the head should be closely examined for fracture lines through the skull base or air-fluid levels in the sphenoid sinus (repeat Figure 1). Figure 2 shows another example of a fracture through the basisphenoid with air-fluid level in sphenoid sinus. Figure 3 shows blood in mastoid air cells (lower arrow) and a small pneumocephalus (upper arrow), indicating a fracture through the temporal bone. Fractures which are not clearly seen on axial C.T. slices may be obvious on coronal slices.

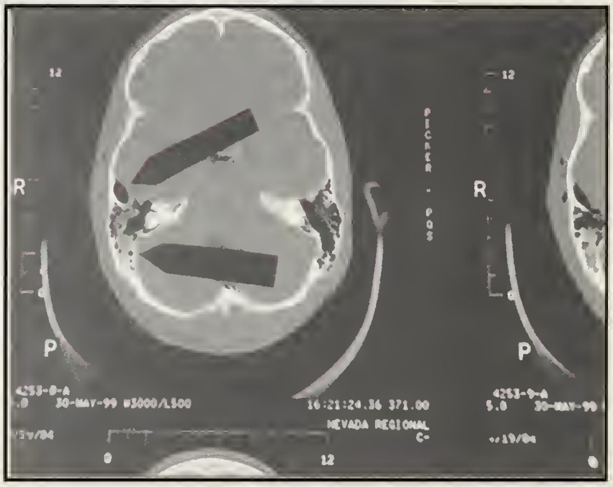

Figure 3

Option A, Le Forte III facial injury is incorrect since no fluid is seen in the maxillary sinuses, andpterygoid plates of the sphenoid appear intact.

Option C, subdural hematoma cannot be diagnosed on images submitted which do not include brain windows.

Option D, orbital blowout fracture represents a fracture of orbital floor or medial wall resulting from a direct blow to the eye. This would result in fluid in maxillary or ethmoid sinuses, not seen on the test case.

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The Importance of Mammography

Carl G. Bynum, DO, MPH

Despite the importance of early detection and treatment of breast cancer, many women are not receiving routine mammography screening examinations. Next to skin cancer, breast cancer is the most frequent cancer in women. Authorities predict new cases of invasive breast cancer in 1999 to approach 175,000 with an associated 43,000 deaths.[1] Despite the facts of high morbidity and mortality associated with breast cancer and that early detection is essential in breast cancer treatment, clinicians still underutilize the services of routine mammography.

To increase the mammography rates in women, understanding the epidemiology and nature of breast cancer is essential. Likewise, realizing the consequences of not diagnosing the disease early is important, since this delay leads to a delay in treatment. It is well established that as women age, their risk of developing breast cancer increases. For example, the chance of developing breast cancer increases incrementally from 1 out of 50 by age 50, 1 out of 24 by age 60, 1 out of 14 by age 70, to 1 out of 10 by age 80.[2] Although no one knows why some women develop cancer and others do not, it is understood that other factors increase women's risk of developing breast cancer. Investigation of these risk factors is fundamental when deciding at what age to start mammography screening and how often to perform the test. These factors include age (as mentioned above), age at menarche (first period before age 12), age at first birth (first full term birth after age 30), breast cancer among first-degree relatives (mother, sisters, daughters), previous breast biopsies (especially if atypical hyperplasia was present), race (white women have a greater incidence, although black women are more likely to die of the disease) and a history of breast abnormalities (i.e., ductal carcinoma in situ and lobular carcinoma in situ.)[3]

The most effective method to detect breast cancer at an early stage and reduce the chances of dying from the disease is mammography. While experts do not agree on routine mammography screening in women aged 40-49, there is universal agreement about the efficacy and potential cost effectiveness of mammography screening of women aged 50-69.[4] One reason for the hesitancy in screening those younger than 50 is their lower risk of developing breast cancer (only 1 out of 217 by age 40.)[2] Ultimately, however, the decision of when and how often to have a mammogram rests with each woman and her physician. For now, a woman in her 40s should discuss the matter thoroughly with her physician.[5]

The cornerstone in detecting breast cancer is screening mammography. Various clinical trials have shown that screening mammography effectively reduces mortality from breast cancer 20-30% among women aged 50 years and older.[6, 7] While mammography is valuable in detecting early breast cancer, the clinical breast examination (CBE) is also important, since not all breast cancers are seen on a mammogram. The Missouri Patient Care Review Foundation (MPCRF) supports the recommendation that women aged 50-69 should be screened at least biennially for breast cancer and that women in other age groups should be screened depending upon risk factors and personal situations and preferences.

Since this seems so evident, the question remains about why this essential test is not being done. To understand the variables explaining this obvious underutilization of such an important test, discussing what influences the decision in eligible women is important.

Several barriers have been identified that result in women not receiving necessary mammography examinations. Many women report that they have not thought about it, or do not believe one is necessary because they do not have any symptoms, or that their schedule is too busy and simply do not have the time.[8] So, we see that some barriers concern a patient's lack of knowledge or attention. Another area where opportunities are potentially lost is during visits to the physician or other health care provider. Most patient visits are for health problems unrelated to symptoms suggesting breast pathology. However, every patient encounter presents an opportunity to recommend a mammogram, if needed. **Physicians should realize that the most important factor known to result in more women receiving a mammogram is the recommendation for the screening from their physician.** [8] MPCRF encourages you to remember that the earlier breast cancer is found, the better the chances for successful treatment. Take advantage of opportunities for recommending mammography during your office or hospital visits.

As the federally designated Peer Review/ Quality Improvement Organization for Missouri, MPCRF is responsible for conducting quality improvement projects for the state's Medicare beneficiaries. Plans are underway to start an extensive project throughout the state to help beneficiaries and practitioners to improve the rate of screening for breast cancer.

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Lease or Buy Your Car? Consider the Options

Andy Adams

I was talking with my dad the other day. I was explaining the advantages of leasing my car and how it has benefitted me. I pointed out that even though I was driving a more expensive car, my monthly payment was much lower than his. He just couldn't grasp the concept of paying for a car and not owning it. When I asked him this, it finally clicked: I asked him how many times he had actually paid off his car, and had no car payment? He said he had never paid off a car. He just traded them in every few years and got a new one. So I said: You mean you have always had a car payment? "Probably always will," he said. I then made my point ... dad has been leasing his car all of his life, but he's just been making higher payments!

With the average price of a new car topping $25,000, more and more drivers are turning to auto leasing. Leasing your new automobile can be an attractive alternative to regular financing for many people and for many reasons.

Since tax reform, the would be advantages of buying a new car have disappeared. The interest write-offs on automobile loans have been eliminated. The investment tax credit may no longer be taken, and sales tax can no longer be deducted. These are just a few of the reasons to consider leasing your next new car.

IS LEASING FOR YOU?

Leasing is for the person who wants a new car every two to four years and doesn't mind making a monthly payment to do so.

Leasing is for people who would like to put less money into a depreciating asset like a car and more money into an appreciating asset like stocks or a money market or mutual fund.

WHAT IS A LEASE?

When you lease, rather than a sizeable down payment you usually end up paying one monthly payment (which is payment for the next 30 days) and then monthly payments for the remaining term usually 24, 36, 48 or even 60 months. When you buy, you make payments based on the total value of the car, say $35,000. When you lease, your payments are lower because the residual value at the end of the contract is taken into account.

The car that cost $35,000 to buy might have a residual value of $22,000 after three years, so you would make payments based on $13,000 not $35,000. By the way, in this realistic scenario, if you had bought the car, your $35,000 investment would have shrunk to $22,000 in only three years!

WHO LEASES?

Auto leasing has long been popular with companies because it preserved cash and business related expenses were allowed as business write-offs. Individual consumers became involved when car prices skyrocketed and their tax benefits went away.

Now if an individual uses his leased car for business, they might have some tax benefits available because their car is leased, in addition to the savings they will realize by lower monthly payments. Regardless of any business use, leasing just costs less.

TYPES OF LEASES

Leases are typically closed end which means as long as the payments are made in a timely fashion and the car is returned at the end of the lease in good condition, you can just walk away. An added advantage is this: if an end value of say

$12,000 is placed on your car, you have the benefit of checking what your car is worth to see if you want to buy it.

As an example, depending on the contract, if your car ends up being worth $15,000, you buy the car and sell it for $3,000 profit. If it's worth $12,000 or less, turn it in and walk away. You have the option, but not the obligation to buy the car.

However, you are responsible for paying for any damage or wear and tear on the vehicle as well as a fee for exceeding the preset mileage limit in the contract, usually an average of 15,000 miles per year.

That brings me to another point. It is important to arrange the term of your lease to how long you actually think you will want the car.

After seeing thousands of lease customers, a good rule of thumb is a term which is no longer than you normally keep your car.

PURCHASE OR BALLOON NOTES

A product that new car dealers are marketing under various names are simply balloon notes. They can also contain a purchase provision in which you agree to make your monthly payments and then buy the car for a predetermined residual value at the end of the contract. Consumers note: Proceed cautiously with purchase agreements.

To make leasing even more attractive and keep the monthly payments lower, some new car dealers are quoting unrealistic residual values. A car that the new car dealer knows will only be worth $17,500 is being quoted at a $23,000 residual value. While this may keep your monthly payments down, you will be paying an inflated price for the car when you buy it at the end of the term. This would also prevent you from trading out of your lease early if you wanted to get a new car, as you would owe much more than what the market value would be.

NO EQUITY?

When you buy a new car, at the end of your contract you have equity in the form of a car. When you lease you have a handful of receipts and no car, which means no equity. True or False?

I have heard people in the past say "But at the end of the lease I don't have anything to show for it." This simply doesn't make sense due to the fact that if you have put down $2,000 and then make $400 payments to buy a car, but put down nothing and make monthly payments of $300 to lease a car, your equity is the $2,000 you save on the down payment and the $100 a month you save on payments. You take that $2,000 and $100 a month and invest it...! There is no better equity than cash, plus you are getting a guaranteed value on your car at the end of a certain period of time. Where else will someone guarantee you what your used car will be worth in a few years if it's in good shape?

WHERE TO LEASE

Who you lease from is more important than what kind of car you choose. It is important to note that there are advantages to leasing from a auto leasing company as opposed to a new car dealership, especially if you like to trade often and change models frequently. For instance, if you lease a convertible from a dealer and then decide four months before your lease is up that you want that new sport utility vehicle which the dealer you leased from doesn't carry, he probably won't be too enthusiastic with the fact that you no longer want his product. An independent leasing company would better be able to suit your needs as they lease all makes and models, and could possibly terminate your current lease early.

There are a lot of dealers out there leasing cars who are not trained or qualified to lease you a car, or are in the learning stage. This is evidenced by their advertising. As an example, you'll see an attractive monthly lease payment on a particular car. You look further and see that you have to pay about $5000 total down payment! This completely circumvents the reason for leasing which is not to have a large down payment. Find out the history of the company, how long they have operated, their reputation and knowledge of leasing.

Andy Adams is an expert on auto leasing, and is president of Autoflex Leasing at 1-800-634-1234.

Take Advantage of MSMA's Newest Membership Benefits

MSMA Program Cuts Malpractice Premiums

MSMA has received a number of inquiries following the launch of its new medical malpractice insurance program for members, which allows physicians to reduce premium costs.

The program provides two major benefits:

1) members pay less for their malpractice insurance;

2) the program makes it easier for physicians to change jobs, since the policy will move with the doctor when he or she leaves the employment of a hospital or a physician's group.

MSMA is assisted in this program by Healthcare Insurance Services (HIS), an insurance broker from Houston, Texas specializing in medical malpractice insurance. HIS acts as the insurance broker for approximately 40,000 physicians around the country. The company is lending its expertise to MSMA to insure the program combines high quality and low rates.

Los Angeles-based Farmers Insurance Group will underwrite the policies, something the business has done for 50 years.

According to Farmers, they will offer a minimum of 10-15 percent discount from what most physicians pay now. Farmers has assured MSMA it will meet or beat the rates now available.

If you are interested in receiving a bid to compare to your current premiums, call Tim Aguilar or Hal Kinsey of HIS at 800-733-4474.

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The Missouri State Medical Association has established a network of attorneys for the purpose of reviewing physician employment contracts. The four selected are:

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Springfield	417-883-7411
◆ David Patzman	Morrison Hecker
Kansas City	816-691-2731

The above have significant experience in physician employment contracts and offer fair prices. Although they have been recommended by the MSMA, please note that we are not responsible for any advice rendered or acted upon.

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MSMA is pleased to make available a tax-qualified MSA health insurance plan for physicians with self-employment income*. Below is an outline of how Golden Rule Insurance MSAs work to your advantage.

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4) Withdrawals from the account to pay qualified medical expenses (including dental and vision expenses) are never taxed or penalized.

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6) At age 65, withdrawals for any non-qualified purpose are subject only to tax, not a penalty.

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Tuberculosis Screening in Kansas City Homeless Shelters

Ron G. Griffin, MPH and Gerald L. Hoff, PhD

Abstract

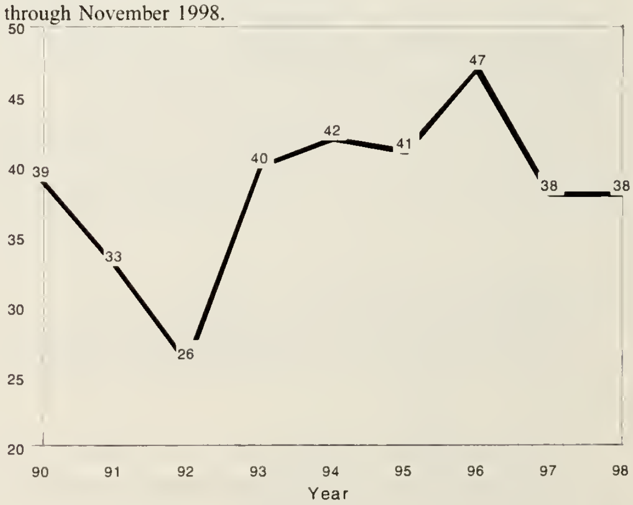
Voluntary tuberculin skin testing, coupled with on-site radiographic examination of persons with indurations ≥ 10 mm, was conducted in five homeless shelters in Kansas City. Of 856 skin tests administered, 654 were read and 89 (13.6%) were positive. Males were nearly four times as likely to have a positive skin test than females. None of the positive individuals had abnormal chest radiographs. Of 42 persons who initiated preventive therapy, only eight completed the course of treatment.

Homeless persons suffer disproportionately from a variety of health problems, including tuberculosis (TB). These individuals are at a greater risk of developing TB due to psychological stress, alcoholism and other substance abuse, and nutritional deficiencies. Recent investigations have shown a prevalence of 1.6%-6.8% for clinically active TB among selected homeless populations[1 2] and the prevalence of asymptomatic TB infection among the homeless has been reported to be as high as 22%-79%.[3-5] It has been estimated that, at a minimum, 53% of TB cases in the homeless are due to primary infection, in contrast to the estimate of 10% for the general population.[6]

Investigators in Los Angeles looked at the risk factors for TB in the homeless and found that 40% of homeless persons in the urban Skid Row area had positive TB skin tests compared with 14% of homeless persons in the suburban Westside area.[7] Compared to persons living in traditional housing (hotel, apartment, or house), persons living in limited shelters, such as abandoned buildings, cars, or all night theaters, were 3.5 times more apt to test positive, and those living on the streets were 2.5 times more likely to test positive. The likelihood of skin test positivity increased dramatically after an individual has been homeless for 10 years (quadrupling the risk), but was relatively constant up to that point. This may account for why older homeless persons were more apt to test positive. Although alcohol/drug abuse and having been in prison are considered predictors of TB in the general population, these factors were not important predictors of skin test positivity among the homeless.

On the average, 38 cases per year of active TB have been reported among Kansas City residents since 1990 (Figure 1). Of the 306 cases during this time frame, 19 individuals were homeless. In each case, tuberculin skin testing of other homeless persons in contact with the index cases failed to identify any additional active TB cases. Up until 1996, homeless individuals were not a significant percentage of the TB morbidity (6.2%), however that year, 26% of the cases were amongst the homeless. Therefore, during the Fall of 1997 and the Spring of 1998, the Health Department conducted tuberculin skin test screening at five major homeless shelters in Kansas City to ascertain the prevalence of asymptomatic infection in the residents of the shelters. The results of that screening are presented here.

Figure 1. Reported Tuberculosis Cases, Kansas City, MO, 1990 through November 1998.



Methods

The tuberculin screening project was conducted in conjunction with regularly scheduled mobile health clinics conducted by Swope Parkway Health Center at five major shelters for the homeless. A nurse from the Health Center administered the Mantoux skin tests to shelter residents who agreed to be tested. This same individual and a TB nurse from the Health Department read the results. Two-step testing was not attempted. The skin test reaction was considered positive if the induration was ≥ 10 mm.

At the time the skin tests were read, the Health Department had available, on-site, x-ray services for those individuals who had positive reactions. The mobile x-ray service was a contract arrangement simply for taking the chest radiographs. Interpretation of the films was done by the physicians staffing the Health Department's TB clinic.

Results

A total of 856 skin tests were administered and 654 (76%) were read. The overall positivity rate was 13.6% (89/654), however, it varied significantly between the five shelters (Chi Square, $p < 0.02$) (Table 1). For every female administered a tuberculin skin test, 5.5 males also received a test (131 females; 725 males). Essentially equal percentages of males and females returned to have their tests read, 76% and 78%, respectively. Males were nearly four times as likely to have a positive skin test than females, 85 and 4, respectively (Fisher's exact Chi square, $p= 0.000857$). Among the three major racial/ethnic groups tested, Hispanics had the lowest return rate, but highest rate of positive skin tests (Table 2). Whites, on the other hand, had the highest return rate and lowest positivity rate, while African-Americans and Asians were intermediate in both categories. Age was known for 92% of the persons whose skin test was read and for all but one of the skin test positives (Table 3). There was no significant difference in prevalence for those age groups 16 years and older (Chi square, $p > .05$). None of the tuberculin skin positive individuals had abnormal chest radiographs.

Of the 89 tuberculin skin test positive individuals, 42 agreed to initiate preventive therapy. Only eight (19%) finished their preventive therapy. One person who had moved out of state after completing two months of therapy, presented to the Health Department in December 1998 requesting and receiving a recommencement of preventive therapy. Of those not completing therapy, two were discontinued by physician orders, two (including the individual described above) moved out of state, 15 became non-compliant and another 15 were lost to follow-up.

Table 1. Tuberculin Skin Testing in Five Major Homeless Shelters, Kansas City, MO.

Shelter	Tests Administered	Tests Read	Tests Positive	Percent Positive
A	252	191	26	13.6
B	135	93	22	23.7
C	126	97	9	9.3
D	157	139	12	8.7
E	186	134	20	14.9
Total	856	654	89	13.6

Discussion

Overall, the prevalence of tuberculin skin test positivity among homeless persons at five major shelters in Kansas City was 13.6%, a level considerably less than that reported for homeless persons in some communities, and higher than the 5-10% prevalence expected in the general population of the United States.[8] The prevalence rate for white, homeless individuals did not differ from that which would be expected in the general population, however, minorities had higher prevalences. This discrepancy mirrors the prevalence of active TB in the general population where the burden of disease is in the minority subpopulations. There was no increasing trend in prevalence with increasing age, but we did not collect information on how long the individual had been homeless.

The ability to bring the x-ray services on-site was extremely beneficial. Although the radiographs were not read until later, we were able to get chest radiographs on all skin positive individuals. From prior experience, we knew it is extremely difficult to get these individuals into the Health Department clinic for further evaluation. In 1996, out of 86 homeless individuals with a positive skin test, only one presented for a chest radiograph. Contributing

Table 2. Tuberculin Skin Testing of Homeless Persons at Five Major Shelters. Kansas City, MO.

Race/Ethnicity*	# Tested	#Tests Read	%Tests Read	# Positive Tests	% Positive Tests
White	396	321	81	17	5.3
African-American	407	298	73	58	19.5
Hispanic	42	27	64	13	48.1
Asian	10	8	80	1	12.5

*There was one person for whom race/ethnicity is unknown.

Table 3. Percentage of Positive Tuberculin Skin Tests for 604 Homeless Persons of Known Age, Kansas City, MO.

Age Category (Years)	# Tested	# Tests Read	% Tests Read	# Tests Positive	% Tests Positive
0-4	9	9	100.0	0	0.0
5-15	12	11	91.7	0	0.0
16-34	239	161	67.4	27	16.8
35-44	297	207	69.7	26	12.6
45-64	238	199	83.6	33	16.6
≥ 65	21	17	81.0	2	11.8

factors to this poor response were 1) that most of the homeless persons worked and could not afford a day off to come in for further evaluation, and 2) the shelters had an early evening lock-down time, usually 7 PM, by which the persons had to be in the shelter or be denied access for the night. It was reassuring to learn that none of the 89 skin test positive individuals in the current study had radiographic evidence of active TB.

Overall, about a quarter of the persons who were administered a tuberculin skin test failed to have that test read. One unanswered question is whether, had these persons been evaluated, would the skin positivity rates for the different racial/ethnic groups gone up or down. Another question is whether there was any active TB among those individuals. As for the first question, we simply have no idea. No incentives were offered to participate in the screening program and none were offered in order to entice people to have their tests read. Whether offering incentives would have resulted in greater participation and/or higher percentages of tests read remains speculative, although incentives have been reported to increase compliance with therapy whether preventive or therapeutic. One problem with incentives is that they must be tied into what the individual perceives as "worth the effort."[9] For example, among injecting drug users, a switch to non-monetary incentives resulted in significant declines in participation with HIV risk reduction programs.[10] Incentives, however, may have improved the 19% completion rate of preventive therapy which in this study was considerably below the 45-55% expected with the general population.

The answer to the second question most probably was no since the shelter staffs were very cognizant of the symptoms of TB and they did not suspect any clients of being clinically ill. Subsequent to the study, three cases of TB were diagnosed in homeless individuals from the same shelters that had participated in the study. Two individuals were reported in July 1998 but had not been in the shelters during the study nor had they been tested previously by Swope Parkway Health Center. In September 1998, a third TB case was reported out of one of the shelters who also had not been in residence during the study. That individual, however, had been screened in July 1997 by Swope Parkway Health Center and found to have an 8 mm induration. No further evaluation had occurred nor was preventive therapy initiated since this reading was considered "negative".

The utility of the present study was that it provided baseline information on the prevalence of positive Mantoux tuberculin skin tests among homeless individuals in Kansas City. There was a very low expectation that active cases of disease would be found and none were detected. And, by having the mobile x-ray on site, 100% of the skin test positive individuals received radiographic evaluation compared to only 1.2% when homeless individuals had to present to the Health Department for evaluation. The low rate of completion of preventive therapy remains a concern.

Acknowledgments

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Dr. Bean is among a national network of over 1,800 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities.

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The book has received favorable reviews from Peter Newman, host of Moneyline on KMBZ in Kansas City, and Walt Bodine, of the Public Radio Network. "He wishes he had the experiences and knowledge to have written this book 10 years ago. But, fortunately now he has done it. So, read it. Learn from it - and enjoy," says Tom Leathers, publisher.

Dr. Germann can be contacted at 913-648-2211 or dgermann@aol.com

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Albert Boldizar, MD, 88, Richmond Heights, died August 31, 1999. He was a retired ophthalmologist and a member of the Missouri State Medical Association.

John Hobbs, MD, 98, Oregon, died August 3, 1999. Dr. Hobbs was an obstetrican/gynecologist and a member of the Missouri State Medical Association.

Ben Koon, MD, 69, Bolivar, died July 31, 1999. Dr. Koon was named Family Physician of the Year in 1995 by the Missouri Academy of Family Physicians. He was a member of the Missouri State Medical Association.

Toshio Nishi, MD, 84, St. Louis, died August 19, 1999. Dr. Nishi was a pathologist and a member of the Missouri State Medical Association.

Burnet Peden, MD, 78, St. Louis, died August 4, 1999. Dr. Peden was a retired internist and a member of the Missouri State Medical Association.

Burchard Pruett, MD, 93, Arizona, died July 30, 1999. He was a family practitioner and a member of the Missouri State Medical Association.

Richard Sterkel, MD, 73, St. Louis, died August 2, 1999. Dr. Sterkel was an internist and a member of the Missouri State Medical Association.

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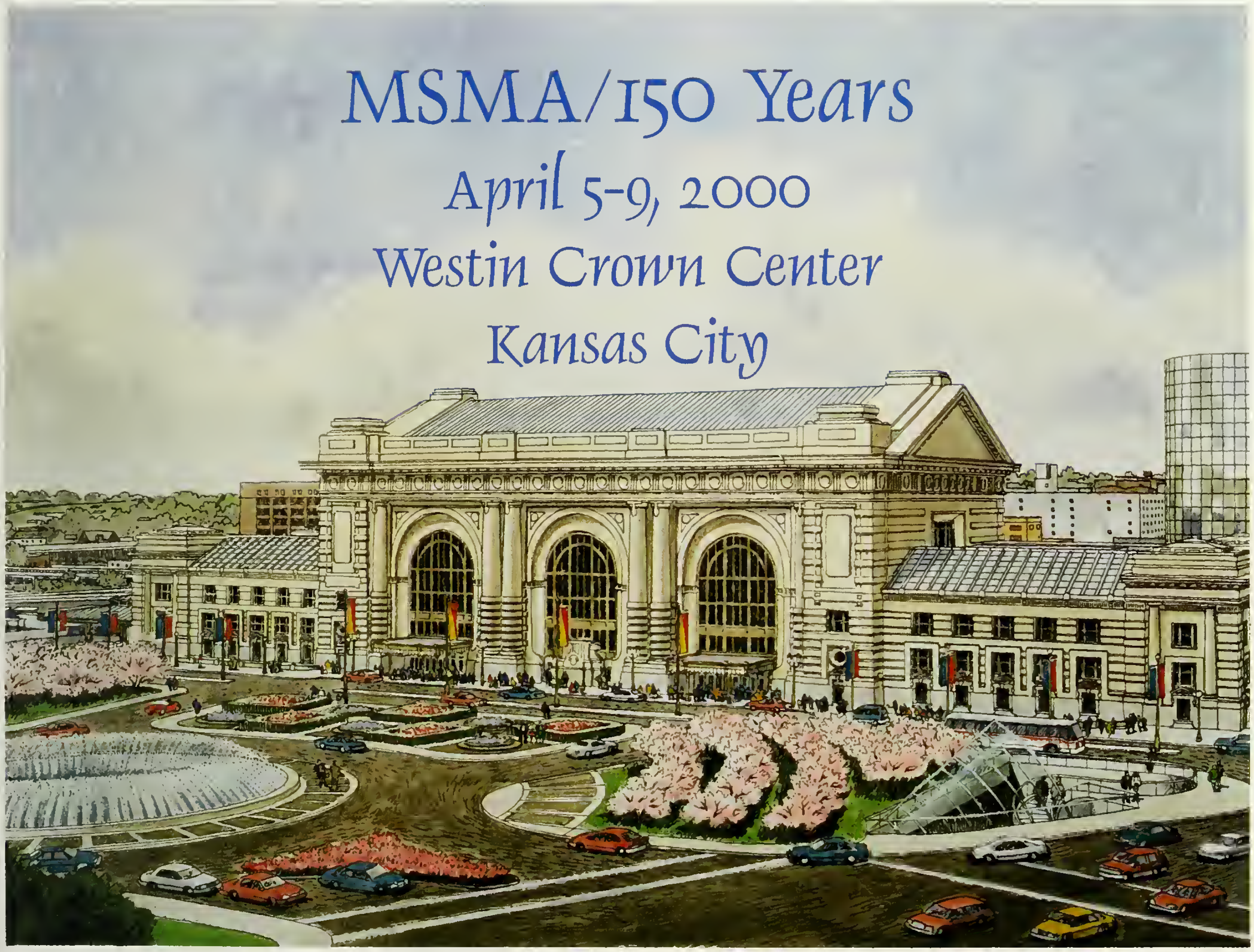

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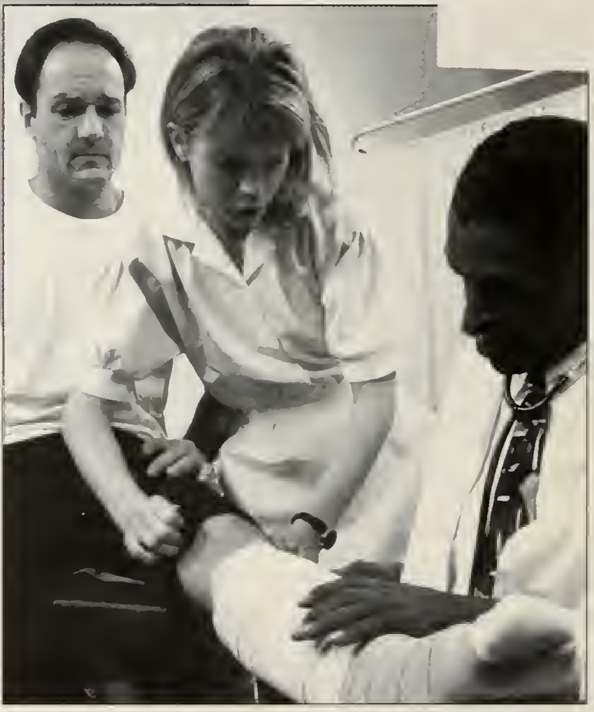

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Missouri Medicine

Journal of the Missouri State Medical Association November 1999

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Editor's Desk

Everyone is Watching

J. Regan Thomas, MD

The specifics are being worked out and there are still some significant issues to be settled. One thing for sure is that everyone is watching to see what will happen as the AMA presents it's new "doctor's union" this year. The AMA is calling it's new union an acronym PRN, which officially stands for Physicians for Responsible Negotiations and of course also uses the play on words addition meaning for PRN, "as needed." A catchy name which the AMA says they picked in order to imply that the goal is for physicians to settle their grievances in some other way if possible. If it is not possible, then this unique union approach is available as needed.

It is, in fact, a unique union if you compare it to more traditional unionized organizations. It doesn't call strikes and in theory it doesn't recruit new member doctors. Hopefully, we won't see physicians carrying picket signs and setting up picket lines. PRNs plan is to supply infor-mation and expertise physicians need to organize their own local groups to bargain and negotiate at the local level. PRN can then interact with the National Labor Relations Board (NLRB) on behalf of those physician groups as though they are "union locals."

In reality, right now most doctors would not be able to join a union since they are self-employed. Present laws and regulations ban collective bargaining (the real goal of having a union) by self-employed individuals. But there are presently about 110,000 doctors who are employed by hospitals or municipalities and about 40,000 presently belong to some type of union according to the AMA. Also there are ongoing discussions at the NLRB as to whether residents are students or employees. If the discussions favors the employee status, then another 95,000 physicians would be eligible to join a union. Certainly, most people feel the numbers of physicians who practice in an employed setting is likely to continue to increase in the near future.

> One thing for sure, they are worried and that's probably a good sign. Certainly, everyone is watching.

Now, the AMA is actively lobbying the Federal Trade Commission (FTC) to exempt physicians from the anti-trust laws which prohibit self-employed doctors to participate in collective bargaining. They also are drafting model legislation for states to use to allow collective bargaining.

Not everyone is happy about these developments and efforts. Insurance companies and HMOs are of course against the concept and argue that health care costs will escalate. Legislators who have ties to these groups are also feeling the pressure to avoid alienating physicians while maintaining campaign donations from the big companies.

For most of us, the thought of a doctors' union seemed foreign. Images of perhaps unprofessional behavior that some of us associated with union membership, like membership hall rallies, picket lines, and strikes, just didn't seem to fit well. PRN may be the combination of professionalism while allowing greatest leverage with the managed care and insurance industries. One thing for sure, they are worried and that's probably a good sign. Certainly, everyone is watching and as noted by the Associated Press in a recent syndicated story, "the AMA has changed the landscape by getting involved."

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Grassroots

William Dorzab, MD

Anyone involved in any aspect of politics is aware of the primacy of this concept. Every politician wants to be on the "right" side of the issue. Every politician would like to be a statesman and serve his/her state or country as a whole. Listening to impartial experts or knowledgeable lobbyists of interested parties can help a legislator understand the issues. But when the "rubber meets the road" persons elected to pass our laws are most concerned with the opinions of their electorates.

There are at least two kinds of people in a legislator's constituency: those who only vote, and those who vote and influence the voting of others. When medical issues are at hand, physicians can play several roles in the legislative process. They vote, to be sure. But they are also the source of information about a broad range of medically-related issues. They play an indispensable role in the education of legislators, the news media and their voter patients.

When physicians take the time to aggressively exercise influence, they may have dramatic effect on the legislative process. I am always amazed at how hungry legislators are to hear physicians' opinions. Most Senators and Representatives, especially at the national level, have at least one staff member responsible for being an expert on medical issues. If the staff has trust and confidence in a particular physician, that physician can become a constant source of information and perspective on medically-oriented legislation.

Achieving such trust and confidence may be quite easy, especially if a legislator or staff member is the patient of the physician. Even without the advantage of a physician/patient relationship, legislators are generally open to physicians and the special expertise and perspective they can bring.

In an effort to facilitate physician involvement in the political process, the American Medical Association sponsors its yearly Grassroots Conference. Last September your President attended this year's meeting with a cadre of Missouri physicians and Tom Holloway, MSMA's Director of Government Relations.

Appearances by Representative Greg Ganske, MD, of Iowa; Senator Edward Kennedy of Massachusetts; Senator Peter Fitzgerald of Illinois, Representative Charles Norwood, DDS, of Georgia, and Representative Michael Bilirakis, of Florida, stimulated participants' attention. A legislative interactive discussion was later conducted by physician legislators Ernie Fletcher, MD, Jim McDermott, MD, Vic Snyder, MD, and Dave Weldon, MD. A special appearance was also made by Vice President Al Gore.

This impressive group was quite educational. Perspective was added by AMA Staff, and other consultants, and attendees used their new-found knowledge to "storm" Capitol Hill and visit with their Congresspersons.

In order to more comprehensively aid physicians when they function as a grassroots source to their Congresspersons the AMA has instituted several programs. The AMA Grassroots Network already has 100,000 Grassroots Activists enrolled. The Network uses blast faxes, and the "CyberDocs" get weekly e-mail updates.

The AMA also has a toll-free Grassroots Hotline (1-800-833-6354), where members can receive daily/weekly Congressional updates, talking points, and sample letters (by fax-back) and direct connection to Senators and Representatives.

The "AMA in Washington" web site and the AMA Grassroots Action Center (www.ama-assn.org/grassroots) is a great source of more detailed information of testimony before Congress, talking points, reference materials, regulatory updates, and links to federal agencies.

Soon the AMA hopes to have a functional system to help physicians enlist the input of their patients to Congress. This will give physicians an avenue to broaden their impact when they have discussions with their patients, who may then wish to contact Congress.

Why not sign on to the Grassroots Action Center (congress.nw.dc.us/ama) and sign up for CyberDocs? You will also have access to House and Senate Floor and Committee Schedules, a zip code directory to help you find your Legislators and the ability to send faxes or e-mails to Congress in a way that can be followed and monitored by AMA Staff. **MoMed**

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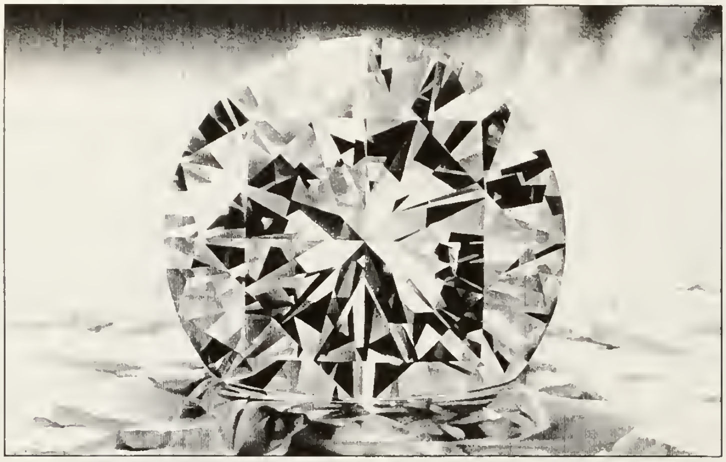

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Physicians Helping Physicians

Lizabeth R. Starnes, MSMA Director of Communications

Where do physicians go when they are stressed?

No, this isn't a joke or a trick question. The answer lies differently with each doctor. Perhaps you travel to places in your mind or your memories, take a walk in the woods with a quiet stream, ride a rolling treadmill or clank the weights in the exercise room, share a conversation with a close friend.

Everyone needs these outlets to restore or refresh, and yet physicians are trained to be stoic, strong, unbending, all-knowing. How do you know when to retreat to your place of peace?

Physicians at Boone Hospital Center in Columbia, Missouri, are turning to each other for answers, for comfort, for contribution, and for a comrade-in-arms in which no one else can share save a doctor. This sharing has a structure, but it's not an impaired physician program, nor is it managed with drugs or other forms of therapy. It's managed from within - within the doctor.

"It's a mind, body, spirit connection," said Dr. Jeffery Belden, a family physician practicing at Boone, who is the volunteer physician guiding the program. "It's a system to nurture doctors, to build attitudes, to support a doctor's well-being." Dr. Belden is serious about the body, mind, spirit equation - it is stated on his business card. "It's what I believe in," he said.

Officially, it is called Doc2Doc, and it's in its third year of encouraging doctors to focus on their own well-being. Physicians who are struggling with family, with burnout, or with group practice politics have an outlet for support at Boone.

"We're sending the message that it's ok to consider yourself in all of this. We're trained to be a good doctor, but the character traits of compulsiveness, perfectionism, and attention to detail that make you a good doctor do not necessarily make you a good friend, a good husband or a good father," said Dr. Belden.

Doc2Doc is an evolution to the next higher form, according to Michael Shirk, President of Boone Hospital. "Doctors are my customers, and I'm a big customer advocate," he said. Boone Hospital's mission is "to improve the health of the people and communities we serve," which is stated on a small plastic card given to all hospital employees, including doctors and nurses. It's a mission that has helped drive the Doc2Doc program.

"Helping family and patients cope with the disease process is very important," said Mr. Shirk. "Health care is more than taking care of the body. It's taking care of the body, mind, and spirit. Supporting this relationship impacts my bottom line. If the patient is healthy, our hospital is healthy. And, if our doctors need a program for their needs, we will develop it."

Boone has an employee-assistance program to support nonmedical personnel in their troubles. In addition, nurses have an ethics committee to turn to when patient care questions need answering. But what about the doctors?

"It's a mind, body, spirit connection, It's a system to nurture doctors, to build attitudes, to support a doctor's well-being."

Dr. Jeffery Belden, a family physician practicing at Boone Hospital, who is the volunteer physician guiding Doc2Doc.

In the September 13, 1999, issue of *Newsweek*, Dr. Zeev E. Neuwirth, MD, writes an article entitled, "*The Silent Anguish of the Healers - Patients suffer when physicians fall prey to stress.*" "Physicians' distress clearly degrades the quality of their personal interaction with patients. Physicians who are themselves feeling harried and abused will be far less capable of establishing communicative and empathic relationships with their patients." The article outlines a recent survey of 4,500 doctors. Thirty-one percent would choose a different profession if given the chance to start over. The reasons? Work stress and poor control over their work environment.

"Our Doc2Doc program is a place for doctors to go and participate in a non peer-review setting to discuss problems. They now have an outlet to get a better understanding from each other. Doctors need to know that they are not out there alone," said Mr. Shirk. "Since doctors relate better to doctors, they can let down their hair in front of those who they can trust and who care."

The program began when Dr. Belden and Rev. Robert Jais recognized that they had a common interest in assisting physicians with their well-being. Boone's Chaplain, Rev. Jais, is a certified Chaplain in the Association of Professional Chaplains, and has helped train hundreds of Chaplains and helped educate dozens of Supervisors of Clinical Pastoral Education.

"From my perspective, Dr. Belden and I both realized that physicians were being dramatically effected by changes within the profession," said Rev. Jais. "There was the realization that the identity of the profession was being changed without much, if any, discussion about it. Rather than medicine being a traditionally valued effort for healing, practiced by autonomous professionals who primarily looked to the well-being of their patients, it was increasingly changing into a business venture, practiced by highly trained individuals who had to share decision-making about patient care with other individuals who focused upon finances."

"Doctors should run the medical system. If there's a program that we can do to help the doctors, that's in our own best interest."
Mr. Michael Shirk, President
Boone Hospital Center
Columbia, Missouri

"Physicians are being increasingly torn. They are being asked to do things quite differently than they had been free to do them, by being asked to share the authority for patient care while still having full responsibility. Also, physicians are being asked to accept increasing levels of stress without an acknowledgment of this fact. Nor are there programs to assist physicians going through the stresses of these dramatic changes," said Rev. Jais.

This formed the basis of Doc2Doc. "The goals are simple: to help normal physicians get through what we hope is an abnormal time for physicians; and, to help them recognize it and get through it together," said Rev. Jais.

In the three years that this program has been growing, "we've been experimenting as we go," said Dr. Belden. "We have no 'model', but our program is maturing as our doctors become involved and learn that it's ok to seek support."

"We want physicians to know that it is important to take care of themselves," he said. "Taking care of yourself has a ripple effect throughout the entire family, the patients, and the community. We want physicians to know there are professionals who are interested in being a resource for solutions to their problems."

The *Newsweek* article seems to corroborate this theory. The author states that scientific research is discovering that patient health outcomes are most correlated with the quality of the relationships that doctors establish with their patients.

To that end, the uniqueness of the program appears to be an attempt to manage normal stressful issues that impact physicians. "In a sense it is an attempt to further the development of a physician community. It speaks to 'community' rather than to a gathering of individuals who happen to work at the same facility," said Rev. Jais. "Our hope is to be of some assistance to physicians to help one another to recognize, address, and talk about the changes occurring in their world."

Religion is not a part of the program, according to Rev. Jais, but spirituality is. "Since these are confusing times in terms of spirituality, I would like to define spirituality in terms of 'being'. We normally are thinking and doing creatures. We have lost the sense of 'being'. The personal side of Doc2Doc is the 'spiritual/being' part of the program. Put into more familiar terms: being together in the practice of medicine, being a family person, just being alone with yourself, being in love."

Rev. Jais ran a similar program prior to coming to Boone six years ago. He was Director of Pastoral Care and Education at Northwestern Memorial Hospital in Chicago for 18 years, having spent the prior seven years as a Chaplain Supervisor at Rush-Presbytenian- St. Luke's Medical Center in Chicago. While at Northwestern, he held a faculty appointment in the Department of Community Medicine, was on the hospital's ethics committee, and helped to initiate the palliative care/hospice program.

Before Rev. Jais accepted his new position at Boone Hospital Center he asked that part of his job description be related to serving the physician population, as he did at Northwestern. Dr. Belden was known by the Director of Chaplains to have a similar interest. Therefore, once Rev. Jais arrived, the connection was made and the initiation was begun.

Rev. Jais and Dr. Belden approached Mr. Shirk, the Chief of Staff (first Dr. Vincent Gurucharri and now Dr. H. Jerry Murrell), and Rev. Jais' administrator, Rev. Dick Millspaugh, to discuss this type of program. Then, the hospital's Continuing Medical Education Committee became involved. After receiving secretarial and funding support, a survey was sent to the medical staff in October 1996 to inquire whether doctors were interested in such a program. The response was quite positive. The challenge then became to find the right format and the right time to offer different speakers and topics to the participating physicians.

"Our hope is to be of some assistance to physicians to help one another to recognize, address, and talk about the changes occurring in their world."

Reverend Robert Jais
Boone Hospital Center
Chaplain

"We have had breakfast, lunch, and dinner meetings," said Rev. Jais. "Initially, we offered a time to sit together while allowing the physicians an opportunity to talk about what they wanted to talk about. Then we moved into a method of offering an article or chapter of a book and then having a time for discussion."

"We evolved to a monthly lunch meeting, with a topic offered for discussion. These experiments culminated in our making a significant offering in May this year when we had a nationally-known speaker, Dr. John-Henry Pfifferling, PhD, Director of the Center for Professional Well-Being, to make a weekend presentation. The topic for Friday evening was personally focused, and Saturday's was directed to the physicians' plight of professional changes and how to deal with them," said Rev. Jais.

In October, Doc2Doc sponsored a dinner presentation on the changing professional identity of being a physician. Doc2Doc is also planning three other programs which will be offered by members of the medical staff in the physicians' lounge, which Dr. Belden says is an experiment in location. A March conference (cosponsored with Stephens College in Columbia) will focus upon the significance of medical care changes due to changes in medical care financing.

"Physicians are measured in the number of patients they treat, but we aren't using numbers to measure the success of Doc2Doc, because there is no 'treatment' per se," said Dr. Belden. Physicians attend the programs when they want. There are about 350 on a mailing list to reach all the medical care professionals (including dentists, psychologists, and a few members of other hospitals), and there is a regular mailing list of about 20.

"Our message is that this program is not a 'fix-it'. We send out letters to the medical staff and make presentations at medical staff meetings inviting physicians to participate when they can," said

Dr. Belden. "We want physicians to know that there are others just like them going through troubling times and that we can get through these times together, with help and input and sharing our experiences."

> "Physicians' distress clearly degrades the quality of their personal interaction with patients. Physicians who are themselves feeling harried and abused will be far less capable of establishing communicative and empathic relationships with their patients."
>
> *Dr. Zeev E. Neuwirth, MD, author of "The Silent Anguish of the Healers - Patients suffer when physicians fall prey to stress."*
> *Source: Sept 13-1999 Newsweek*

How do doctors feel about sharing their own problems, when they've been trained to be the rock of health care?

Dr. Neuwirth writes that part of the problem is resistance inside the medical community. "If you bring up the topic among doctors, the room clears out - possibly because of the pain it brings to the surface," he writes. He also noted that medical schools and residency training programs will have to encourage and teach young physicians not only to care for their patients, but to care for themselves and their families.

"There is an expectation of confidentiality," said Dr. Belden. "We establish ground rules every time we meet and agree to the purpose of the meeting, whether it be to discuss medical care, personal well-being, or another topic. There are different levels that physicians open up. We don't push that progression, we let each physician share in their own way."

Are there other programs like this? Rev. Jais has heard from a few Chaplain Supervisors around the country that they are being asked by their institutions to develop 'supportive' programs for physicians. "It appears that knowledgeable administrators and medical heads of departments know and are concerned about what is happening to physicians. But no one seems to know how to offer significant help," he said.

What is the future of Doc2Doc?

"Our grandest hope is that most physicians will know that we are caring about them, and that we are available if we can be of assistance - particularly Dr. Belden," said Rev. Jais. "Clearly, the lesson I have learned in relation to expectations about a program for 'normal' physicians is that whatever is offered has to be of the highest value if physicians are to be attracted to it. This is due to time pressures, and the fact that difficult choices have to be made all the time. Physicians are always asking themselves, 'What is the most valuable way I can spend my time?' "

"Doctors need emotional energy to deal with their patients and with their families. Doc2Doc encourages doctors to open up, to restore that energy," said Dr. Belden. "Let your life speak, and speak the truth. It's always good to share in a safe place."

Mr. Shirk agrees. "Doctors should run the medical system. If there's a program that we can do to help the doctors, that's in our own best interest." He wants to see the program continue. "Having compassion for yourself is the beginning to having compassion for others," said Mr. Shirk. "There's a feeling of hope that will influence the outcome."

And perhaps it is the feeling of hope that nourishes the body, the mind, and the spirit - a triage that keeps us whole. **MoMed**

If you have questions about the Doc2Doc program or would like to contact Dr. Belden and Rev. Jais, please call or write:

Jeff Belden, MD
Family Physician
1506 E. Broadway
Columbia, MO 65201
Tel: 573-449-0808
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Columbia, MO 65201
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rjais@bjcmail.carenet.org

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President
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Columbia, MO 65201
Tel: 573-815-3210
mshirk@bjcmail.carenet.org

Take Advantage of MSMA's Newest Membership Benefits

MSMA Program Cuts Malpractice Premiums

MSMA has received a number of inquiries following the launch of its new medical malpractice insurance program for members, which allows physicians to reduce premium costs.

The program provides two major benefits:

1) members pay less for their malpractice insurance;

2) the program makes it easier for physicians to change jobs, since the policy will move with the doctor when he or she leaves the employment of a hospital or a physician's group.

MSMA is assisted in this program by Healthcare Insurance Services (HIS), an insurance broker from Houston, Texas specializing in medical malpractice insurance. HIS acts as the insurance broker for approximately 40,000 physicians around the country. The company is lending its expertise to MSMA to insure the program combines high quality and low rates.

Los Angeles-based Farmers Insurance Group will underwrite the policies, something the business has done for 50 years.

According to Farmers, they will offer a minimum of 10-15 percent discount from what most physicians pay now. Farmers has assured MSMA it will meet or beat the rates now available.

If you are interested in receiving a bid to compare to your current premiums, call Tim Aguilar or Hal Kinsey of HIS at 800-733-4474.

Use MSMA's Contract Review Service

The Missouri State Medical Association has established a network of attorneys for the purpose of reviewing physician employment contracts. The four selected are:

◆ Randy Gerber St. Louis	Gallop, Johnson & Neuman 314-615-6217
◆ Craig Van Matre Columbia	Van Matre and Harrison 573-874-7777
◆ Bill Mauck Springfield	Yates Mauck 417-883-7411
◆ David Patzman Kansas City	Morrison Hecker 816-691-2731

The above have significant experience in physician employment contracts and offer fair prices. Although they have been recommended by the MSMA, please note that we are not responsible for any advice rendered or acted upon.

Looking For a New Job?

Medical Employment Directory is a Missouri company specializing in physician placement that has recently been endorsed by MSMA. With five offices statewide, MED's four placement divisions include: physician recruitment, permanent placement, temporary staffing, and human resource consulting. Each personnel counselor is a medical professional with a knowledge of licensing requirements and certifications.

MED is successful at matching physicians to opportunities based on their needs for practice structure, family, personal considerations, and economic potential. Retention rate is 99%. Over 100 practice opportunities are listed with MED. Visit MED's web site at *www.med-search.com* or call 816-756-3445.

MSMA's Medical Savings Accounts

MSMA is pleased to make available a tax-qualified MSA health insurance plan for physicians with self-employment income*. Below is an outline of how Golden Rule Insurance MSAs work to your advantage.

Since MSMA does not hold an insurance license, we cannot answer questions about the plan. So, please call MSMA at 573-636-5151, we will have Golden Rule contact you at your convenience.

. . . .

MSAs come in two parts:

A) High deductible major medical insurance.

B) A tax-qualified account that covers up to 75% of the deductible for a family.

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3) All money in the account earns tax-deferred interest. Another potential source of retirement income.

4) Withdrawals from the account to pay qualified medical expenses (including dental and vision expenses) are never taxed or penalized.

5) Withdrawals from the account to pay long-term care insurance premiums likewise are never taxed or penalized.

6) At age 65, withdrawals for any non-qualified purpose are subject only to tax, not a penalty.

**You probably have self-employment income if: a) you are a sole proprietor; b) you are a partner in a partnership or Limited Liability Corporation; c) you own a greater than 2% share of a Subchapter S Corporation; or d) you are an owner of a Professional Corporation that has elected to be treated as a Subchapter S Corporation.*

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Beneficiary helpline: 1-800-347-1016

Medicare Internet site: medicare.gov

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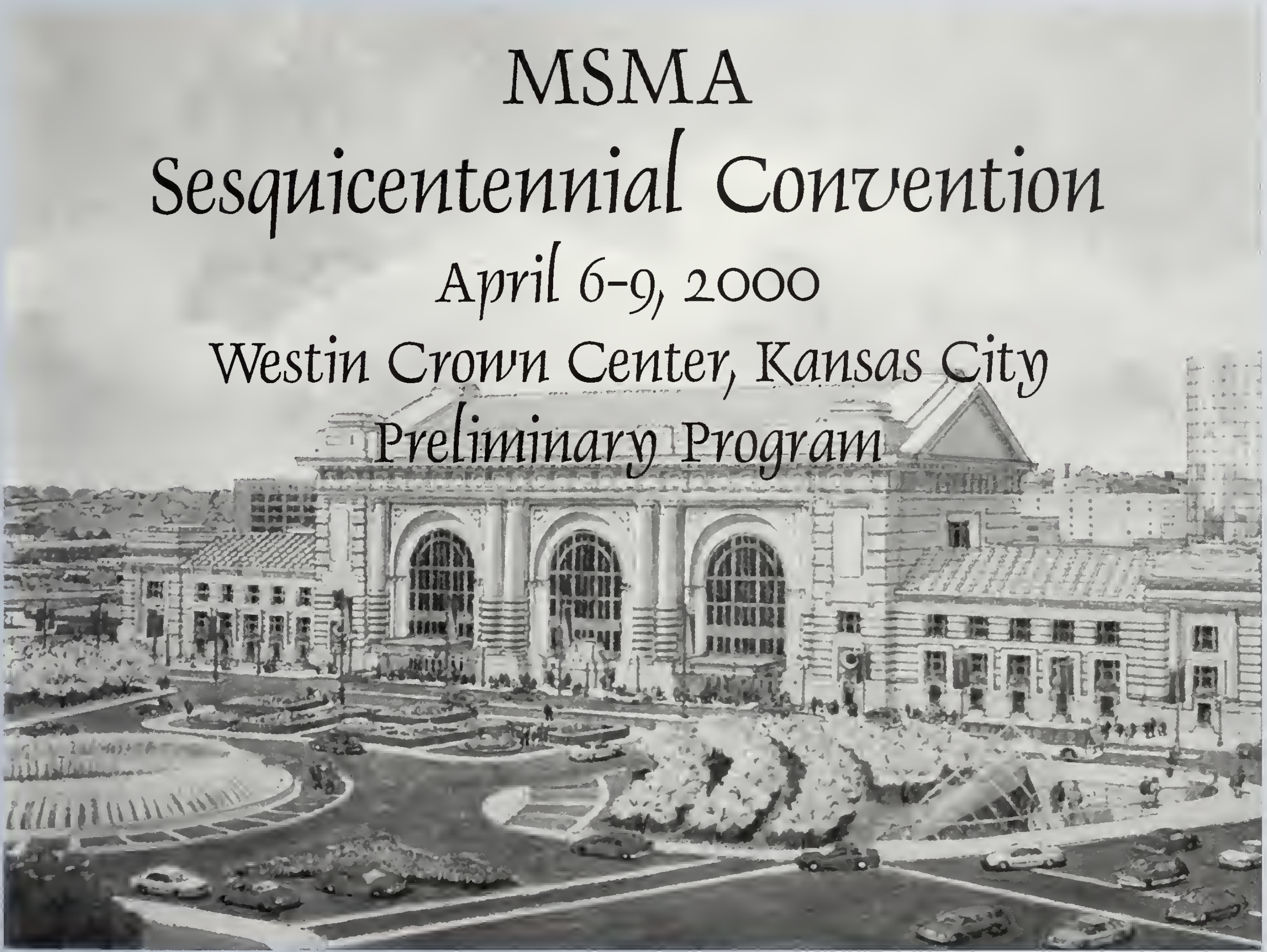
MSMA

Sesquicentennial Convention

April 6-9, 2000

Westin Crown Center, Kansas City

Preliminary Program



Kansas City's restored Union Station will attract more than one million visitors a year when it opens as the home of Science City in November 1999. Physicians will have the opportunity to visit Union Station while attending MSMA's 2000 Annual Convention. Please mark your calendar and plan to join us as MSMA takes medicine into the new millenium and celebrates its 150th anniversary along with the MSMA Alliance celebrating its 75th anniversary.

1850-2000 MSMA
Sesquicentennial
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MISSOURIANS FOR 150 YEARS

1924-1999
75 Years of Caring
Missouri State Medical Association Alliance
PHYSICIANS' SPOUSES DEDICATED
TO THE HEALTH OF MISSOURIANS

Preliminary Program

MSMA Sponsored Events

April 6, Thursday

2:00 pm	Opening Session, MSMA House of Delegates
4:00 pm	Reference Committees Meetings

April 7, Friday

7:00 am	Councilor District Breakfasts
9:00 am	Opening General Session
11:00 am	Open Forum on AMA Issues
11:00 am	Medical Student Luncheon
noon	General Session
4:00 pm	Second Session, MSMA House of Delegates
6:15 pm	Young Physicians Section Business Meeting

April 8, Saturday

7:00 am	Missouri State Medical Foundation Board Meeting
8:00 am	General Session
11:00 am	MMPAC Meeting
1:00 pm	Organized Medical Staff Section Meeting
1:00 pm	International Medical Graduates Meeting
6:30 pm	Presidential Inauguration
7:30 pm	Reception

April 9, Sunday

7:30 am	Final Session, MSMA House of Delegates

Component Medical Societies

April 6, Thursday

noon	St. Louis Metro Luncheon
noon	Metro Med of Greater KC Luncheon

April 7, Friday

7:00 am	Councilor District Breakfasts
noon	Metro Med of Greater KC Luncheon
2:00 pm	St. Louis Metro Caucus

Other Events

April 6, Thursday

6:45 am	Moneta Breakfast

April 7, Friday

7:30 am	UMC Alumni Board of Governors Breakfast Meeting
12:30 pm	UMC Alumni Luncheon
6:00 pm	Alumni Receptions

Exhibits

April 7, Friday

8:00 am	Rolls and Coffee in Exhibit Hall
10:30 am	Intermission to View Exhibits
2:00 pm	Intermission to View Exhibits

April 8, Saturday

8:00 am	Rolls and Coffee in Exhibit Hall
10:30 am	Intermission to View Exhibits

MSMA Sesquicentennial Convention Highlights:

- Election 2000: Candidate Forum
- Educating Physicians about End-of-life Care (EPEC) Project
- EMTALA Regulations (Emergency Medical Treatment and Active Labor Act)
- Unions - Collective Bargaining
- 150th Presidential Inauguration Celebration
- 15 Medical Specialties & Medical Sections
- House of Delegates

Celebrating 150 Years at the 2000 Convention

Specialty Societies

April 7, Friday

11:00 am	Missouri Society of Otolaryngology- Head and Neck Surgery Program
3:00 pm	Missouri State Surgical Society Program
6:00 pm	Missouri Society of Anesthesiologists House of Delegates

April 8, Saturday

7:00 am	Missouri Society of Anesthesiologists Breakfast
7:00 am	Missouri Association of Plastic & Reconstructive Surgery Board Meeting
7:00 am	Missouri Society of Otolaryngology - Head and Neck Surgery Breakfast Meeting
8:00 am	Missouri Society of Radiology Breakfast Meeting
9:30 am	Missouri Association of Plastic and Reconstructive Surgery Program
9:45 am	Missouri Dermatological Society Program
9:45 am	Missouri State Neurological Association Program
10:00 am	Missouri State Surgical Society/Missouri Chapter, American College of Surgeons Program
10:00 am	Missouri Society of Anesthesiologists Program
10:00 am	Missouri Society of Otolaryngology - Head and Neck Surgery Program
11:00 am	Missouri Society of Radiology Program
11:30 am	Central Society of Physical Medicine and Rehabilitation Program
11:30 am	American Cancer Society Liaison Luncheon
noon	Central Society of Physical Medicine and Rehabilitation Luncheon
noon	Missouri Society of Otolaryngology - Head and Neck Surgery Luncheon
noon	Missouri Association of Plastic and Reconstructive Surgery Luncheon
noon	Missouri Society of Anesthesiologists Luncheon
noon	Missouri Society of Radiology Luncheon
1:00 pm	Missouri Society of Radiology Program
1:30 pm	Missouri Society of Anesthesiologists Program
1:30 pm	Central Society of Physical Medicine and Rehabilitation Program
1:30 pm	Missouri Association of Plastic and Reconstructive Surgery Program
3:00 pm	Missouri Society of Anesthesiologists Second House of Delegates

April 9, Sunday

9:30 am	Christian Medical and Dental Society Program

MSMA Alliance

April 6, Thursday

10:00 am	Pre-convention Board Meeting

April 7, Friday

8:00 am	General Session
noon	General Session
7:30 pm	AMA Foundation Fundraiser

April 8, Saturday

8:30 am	General Assembly
3:00 pm	Joint Convention Board Meeting
6:30 pm	Presidential Inauguration
7:30 pm	Reception

Convention Deadlines

January 21 . . . . . . Community Service Award Nominations Due
February 6 . . . . . . Delegate Credential Cards Due
February 21 . . . . . . Resolutions Due

CELEBRATING 150 YEARS AT THE 2000 CONVENTION

MISSOURI STATE MEDICAL ASSOCIATION
SESQUICENTENNIAL CONVENTION

APRIL 6-9, 2000
WESTIN CROWN CENTER
KANSAS CITY, MISSOURI

PREREGISTRATION

Registration for MSMA's Sesquicentennial Convention is *easy!*
FAX: Registration form to 573-636-8552
MAIL: MSMA, P.O. Box 1028, Jefferson City, MO 65102
INTERNET: Register over the Internet at *www.msma.org*.

Name

Mailing Address

City/State/Zip

Delegate ☐ *Member* ☐ *Non-Member* ☐

Daytime Phone Number

Medical Specialty *Component Medical Society*

Upon receipt of your preregistration, you will be mailed a confirmation card to present at the Sesquicentennial Convention registration desk. Your registration packet and name badge will ready for pick-up.

Check the sessions you will be attending:

- _____ *Election 2000: Candidate Forum*
- _____ *EPEC (End-of-Life-Care)*
- _____ *EMTALA Regulations*
- _____ *Unions-Collective Bargaining*
- _____ *Medical Specialty Programs*

HOTEL RESERVATIONS

MISSOURI STATE MEDICAL ASSOCIATION
Sesquicentennial Convention • April 6-9, 2000

Reservations for the Westin Crown Center must be made by **FEBRUARY 21, 2000**, to take advantage of MSMA convention room rates.

TO MAKE RESERVATIONS:

CALL	Westin Crown Center at 816-474-4400 with any major credit card
FAX	Fax the form below to 816-391-4493, ATTN: Caroline
MAIL	Mail the form below to Westin Crown Center, #1 Pershing Road, Kansas City, MO 64108

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Daytime Phone Number *Arrival Date/Time* *Departure Date*

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# Rooms *# Persons* *Single/Double-$110* _____ *One Bedroom Suite-$250* _____ *Two Bedroom Suite-$400* _____

Non-Smoking _____ *Smoking* _____ *Special Needs* _____

Reservations are accepted on a space-available basis, so please make your hotel reservation as soon as possible. Reservations will be accepted and confirmed up to the opening day of the Convention, providing accommodations are still available. Reservations run from 4:00 p.m. on day of arrival until noon on day of departure.

Cancellation Policy: The Westin Crown Center requires an advance of one night's lodging or credit card guarantee to confirm reservations. Deposits are refunded/credited only when cancellation reaches the Westin Crown Center office 24 hours prior to day of arrival. Your deposit will be forfeited if you arrive later. To avoid penalty for early departure, 48 hours notice must be given. This form may be duplicated.

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www.msma.org/medmal.html

EPEC Program Spreads in Missouri

Tracy Strevey, MD, and Robert Phillips, MD

Two physicians sponsored by the MSMA, Tracy Strevey, MD, St. Louis, and Robert Phillips, MD, Columbia, attended the Educating Physicians about End-of-life Care (EPEC) Project in July. The project is supported by the AMA and a grant from The Robert Wood Johnson Foundation. Last month in *Missouri Medicine*, readers were introduced to the program and how it will be implemented through MSMA's Young Physicians Section and other areas. For this article, Drs. Strevey and Phillips put their own personal thoughts on paper for us.

"Thanks to the MSMA and the AMA, we have been privileged to join over 250 physicians and other health care providers in a project designed to educate all U.S. physicians on the essential clinical competencies required to provide quality end-of-life care. The Educating Physicians about End-of-life Care (EPEC) Project is housed within the End-of-life Care Section of the AMA Institute for Ethics," wrote Dr. Phillps.

"The EPEC Project was designed as a train-the-trainer course and has several components. At the heart of the project is a standardized, core curriculum that provides physicians with the basic knowledge and skills needed to appropriately care for dying patients. The *EPEC Curriculum* was designed with help from nationally respected experts and participants of early training conferences. It combines didactic sessions, videotape presentations, interactive discussions, and practical exercises. It teaches fundamental skills in communication, ethical decision-making, palliative care, psycho-social considerations, and pain and symptom management. The curriculum is divided into modules that may be delivered individually or in series."

> "We all remember, I am sure, the first time we had to deal with telling a patient or a family member that death was inevitable or in the near future; I know that I do."
>
> *Tracy Strevey, MD, St. Louis, EPEC Trainee*

"It was both a great pleasure as well as an honor to be sent by MSMA to the EPEC training program for trainers in Chicago in July," offered Dr. Strevey "The program was superbly designed and coordinated with maximum effective utilization of our time, and presentation materials that were professional in quality and utility."

"One of the things that made the session so interesting and valuable was the interaction of physicians from different specialties around an area of great clinical importance," he continues. "In attendance were pediatricians, internists, geriatricians, oncologists, cardiologists, intensivists, surgeons- general, cardiothoracic, oncologic, urologic, etc."

"Of special note, because of the expertise they brought to the discussion, were the physicians specializing in hospice care. There were also several hospice nurses in attendance. The attendees were from all areas of the country and of all ages from residents to physicians in their sixties. The interactive nature of the dialogue was of paramount importance and we were taught how to encourage this discussion in our own future training programs," said Dr. Strevey.

Dr. Phillips said. "This program was one of the best I have ever attended—the materials and faculty were phenomenal but learning from other participants, most of whom were affiliated with hospice care in some way, was definitely a highlight."

"Patients need help in dying with control of pain and other symptoms, with a sense of control, and with dignity. Physicians need to learn how to deal with death in a healthy way in order to help our patients meet these needs. The program taught both exceedingly well," he said.

"The heavy emotional burden of treating a patient at the end-of-life, or during a lingering, life-threatening illness, is one with which we are all familiar," said Dr. Stevey. "The program taught how to deal with this, how to return to the historical role of compassionate supporter and caregiver, and how to use a team to distribute the tasks."

"We all remember, I am sure, the first time we had to deal with telling a patient or a family member that death was inevitable or in the near future; I know that I do," he said. "This program provides a framework within which to deal with these problems in a rational and effective manner. It will be of benefit to any physician, or potentially to any practitioner, who has to face with patients the last days of their lives."

Dr. Phillips reported that the *EPEC Speakers List* includes recommended individuals who are available to speak on topics related to end-of-life care. The *EPEC Resource Guide* provides an annotated list of resource materials and how to obtain them. Most of these resources can be found on the AMA website at http://www.ama-assn.org/ethic/epec/index.htm or by contacting the EPEC office at the address listed below. The *EPEC List Serve* allows individuals who have been trained or who have an interest in EPEC to communicate informally via e-mail.

"The Missouri physicians and other professionals who participated in the EPEC project can also be a resource to you. We are just two of eight trainees from Missouri who you could call on to provide materials or present modules," said Dr. Phillips. "Our charge for having gone through this training is to be available to share this knowledge with our peers. We can be reached through the MSMA and other Missouri trainees are listed on the AMA website noted below. Please help us to educate other Missouri physicians about caring for patients and their families at the end-of-life." **MoMed**

The EPEC Project Institute for Ethics

MSMA
113 Madison St.
Jefferson City, MO 65101
573-636-5151
573-636-8552 (fax)
www.msma.org

American Medical Association
515 N. State Street
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1998 HMO Income

Health Maintenance Organizations Licensed & Active in Missouri in 1998	Total Premium Rated Revenue	MO %	Net Income (Loss)
Aetna US Healthcare, Inc., d/b/a US Healthcare, Inc.	$341,710	75%	$171,329
Alliance for Community Health, Inc., d/b/a A Healthcare Partnership, Community Care Plus	$22,065,634	100%	$225,560
BMA Selectcare, Inc.	0	N/A	$33,385
Children's Mercy Family Plan	0	N/A	$10,544
Children's Mercy Hospital/Truman Medical Center, d/b/a Family Health Partners, Inc.	$37,167,645	100%	($550,940)
CIGNA Healthcare of Ohio, Inc.	$86,813,509	13%	$2,857,337
CIGNA Healthcare of St. Louis, Inc.	$13,525,345	96%	$1,931,937
Community Health Plan	$57,755,818	96%	($7,832,233)
Cox-Freeman Health Plans, Inc.	$22,184,530	100%	($871,349)
Exclusive Healthcare, Inc.	$148,788,321	4%	($37,295,663)
First Guard Health Plan, Inc.	$31,127,426	97%	$189,246
Good Health HMO, Inc.	$78,804,991	74%	$1,430,363
Group Health Plan, Inc.	$409,023,965	65%	($5,075,453)
Health Partners of the Midwest	$141,175,270	95%	$568,389
Healthcare USA of Missouri, LLC	$110,378,950	100%	$3,781,511
HealthLink HMO, Inc.	$36,591,895	97%	$56,388,387
HealthNet, Inc.	$137,662,707	59%	($2,595,998)
HMO Missouri, Inc., d/b/a/ Blue Choice	$206,751,180	100%	($9,725,273)
Humana Health Plans, Inc.	$1,493,832,270	5%	($14,206,366)
Humana Kansas City, Inc.	$207,330,989	69%	$6,648,830
Kaiser Foundation Health Plan of Kansas City, Inc.	$107,266,074	63%	$2,857,820
Mercy Health Plan of Missouri, Inc., d/b/a/ Premier Health Plans	$172,137,817	92%	($7,070,702)
Missouri Advantage, LLC	$11,738,852	97%	($872,060)
MissouriCare	$12,670,542	100%	($3,820,206)
Principal Health Care of Kansas City, Inc.	$123,426,425	25%	$169,765
Principal Health Care Plan of St. Louis, Inc.	$56,547,007	90%	($2,733,946)
Prudential Health Care Plan, Inc.	$3,527,539,316	3%	($63,607,163)
TriSource Health Care, Inc., d/b/a/ Blue Advantage	$119,885,059	80%	($3,600,020)
United Healthcare of the Midwest, Inc.	$874,101,511	92%	$4,553,928
All HMOs Listed Above	$8,246,634,758	32%	($78,039,041)
HMOs with Mo% of Business > 60%	**$2,866,234,917**	**85%**	**$33,999,120**

*Percent Missouri Business is based on premium earned information from the 1998 Annual Statement Premiums, Enrollment and Utilization Table for Missouri

**Excludes CIGNA Healthcare of Ohio, Exclusive Healthcare, Humana Health Plans, Principal Health Care of Kansas City, and Prudential Health Care

Source: Missouri Department of Insurance

1998 HMO Profitability

Health Maintenance Organizations Licensed & Active in Missouri in 1998	1998 MO Loss Ratio	%Change in (1997-98)	1998 Plan Wide Medical Loss Ratio	% Change in (1997-98)
Aetna US Healthcare, Inc., d/b/a US Healthcare, Inc.	95%	N/A	95%	N/A
Alliance for Community Health, Inc., d/b/a A Healthcare Partnership, Community Care Plus	89%	-14%	92%	-12%
Children's Mercy Hospital/Truman Medical Center, d/b/a Family Health Partners, Inc.	0%	-100%	90%	1%
CIGNA Healthcare of Ohio, Inc.	99%	-2%	94%	7%
CIGNA Healthcare of St. Louis, Inc.	69%	-17%	82%	-2%
Community Health Plan	102%	1%	102%	3%
Cox-Freeman Health Plans, Inc.	72%	-21%	86%	-4%
Exclusive Healthcare, Inc.	138%	35%	104%	11%
First Guard Health Plan, Inc.	76%	-5%	76%	-5%
Good Health HMO, Inc.	89%	0%	85%	-4%
Group Health Plan, Inc.	86%	-2%	92%	5%
Health Partners of the Midwest	80%	-8%	84%	-12%
Healthcare USA of Missouri, LLC	84%	-10%	86%	-7%
HealthNet, Inc.*	87%	-3%	84%	-6%
HMO Missouri, Inc., d/b/a/ Blue Choice	100%	-6%	96%	-10%
Humana Health Plans, Inc.	88%	-17%	88%	-3%
Humana Kansas City, Inc.	90%	1%	86%	-4%
Kaiser Foundation Health Plan of Kansas City, Inc.	95%	-2%	91%	-7%
Mercy Health Plan of Missouri, Inc.	102%	-2%	91%	-12%
Missouri Advantage, LLC	109%	30%	88%	0%
MissouriCare	20%	N/A	109%	N/A
Principal Health Care of Kansas City, Inc.	87%	4%	86%	-2%
Principal Health Care Plan of St. Louis, Inc.	N/A	-100%	94%	0%
Prudential Health Care Plan, Inc.	N/A	-100%	90%	1%
TriSource Health Care, Inc., d/b/a/ Blue Advantage	131%	-12%	94%	-6%
United Healthcare of the Midwest, Inc.	85%	-1%	85%	1%
All HMOs Listed Above	88%	-4%	89%	-1%
HMOs with Mo% of Business > 60%**	**88%**	**-2%**	**87%**	**-4%**

Note: HMOs without enrollees in 1998 are not included.
*Percent Missouri Business is based on premium earned information from the 1998 Annual Statement Premiums, Enrollment and Utilization Table for Missouri
**Excludes CIGNA Healthcare of Ohio, Exclusive Healthcare, Humana Health Plans, Principal Health Care of Kansas City, and Prudential Health Care
Source: Missouri Department of Insurance

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CT Findings of Idiopathic Subchoroidal Calcifications

David S. Martin, MD and John Mattingly, MD

CLINICAL IMAGE

CT FINDINGS OF IDIOPATHIC SCLEROCHOROIDAL CALCIFICATIONS

Idiopathic sclerochoroidal calcification (ISC) is an uncommon asymptomatic disorder, typically found in older patients, which results in deposition of calcium within the sclera and choroid. It is typically discovered incidentally on funduscopic examination with the characteristic finding of mildly elevated yellow lesions, usually located superior to the superior temporal retinal vascular arcade bilaterally. Visual acuity is normal because the lesions lie outside the fovea. Patients are commonly referred to an ophthalmologist with the diagnosis of "rule out metastatic lesions." This entity has received little attention because it is asymptomatic. It is not even listed as a cause of bilateral globe calcification in a major work on radiological differential diagnoses[1]. It might surprise an unsuspecting physician who orders a brain CT for other reasons. Therefore, we present the computed tomographic findings and discuss causes of sclerochoroidal calcifications. Computed tomography may be helpful to detect contralateral funduscopically occult calcified choroidal lesions in patients initially thought to have unilateral disease[2].

CASE REPORT

An 83-year-old man presented to his internist with the complaint of sudden loss of vision in his right eye. After evaluation by his primary physician, he was referred to an opthalmologist with the diagnosis of right central retinal artery occlusion as well as multiple posterior nodular lesions to be evaluated for metastatic disease. Ocular examination revealed decreased visual acuity in the right eye with motion detection. His left eye was uninvolved. Funduscopic examination revealed signs of central retinal artery occlusion in the right eye. An additional finding of elevated, multifocal, multinodular choroidal lesions in the region of the superotemporal arcade in both eyes was also noted. Serum electrolyte laboratory examination revealed no abnormalities of calcium metabolism or parathyroid function. Ocular ultrasound (not shown) showed the lesions to exhibit shadowing consistent with calcification. Computed tomography was performed revealing globe calcifications in the posterior globe bilaterally (Fig. 1). Carotid ultrasonography and Holter monitoring was also performed to evaluate for a possible source of emboli.

DISCUSSION

Sclerochoroidal calcification is recognized because it produces a typical, if not classic, funduscopic appearance, including geographic yellow lesions in the posterior segment[3]. Clinically, it may be confused with choroidal osteoma, choroidal metastasis, amelanotic choroidal nevus, or choroiditis[2,4], or retinoblastoma in a child. Radiographically, because of bilateral globe calcifications, it must be distinguished from choroidal osteoma, retinoblastoma, and phthisis bulbi. Choroidal osteoma, a calcified intraocular tumor, is a disorder of young females, mean age 26 years. Funduscopically, the lesion is usually larger and located closer to the macula when compared to sclerochoroidal calcifications. Choroidal osteomas are bilateral in one-third of the cases and may present with visual symptoms such as blurred vision and scotoma. Computed tomography of choroidal osteomas shows dense unilateral or bilateral calcification near the optic nerve disk[5]. Choroidal metastasis are usually not calcified and the funduscopic findings are of larger, thicker plaques

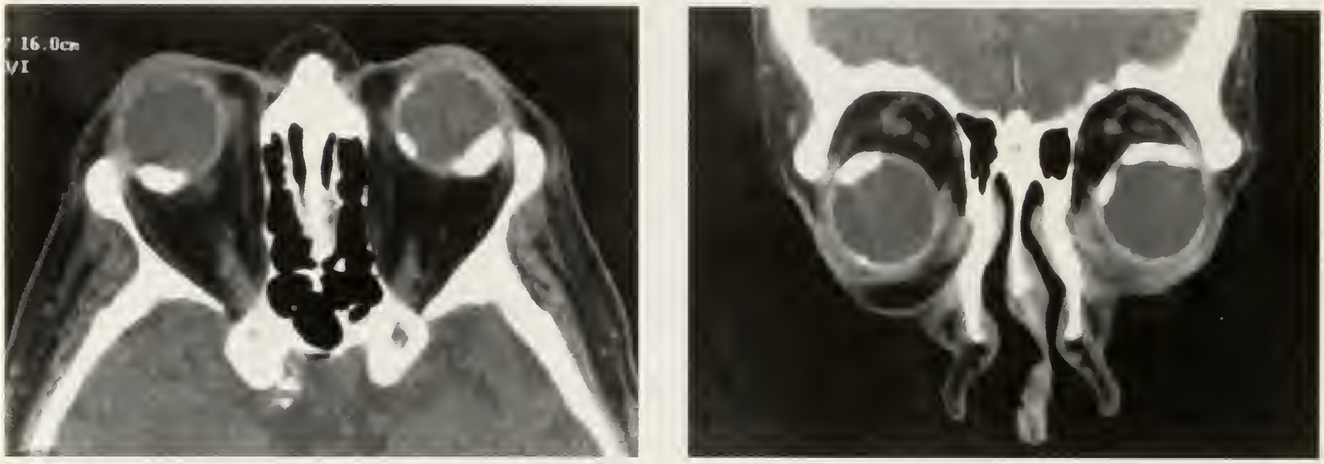

Fig. 1. (A) (left) axial and (B) (right) coronal computed tomograms of the orbits demonstrating bilateral plaque-like choroidal calcifications of the globe primarily located at the superior and lateral aspects of the posterior globe.

often associated with serous retinal detachment[2]. Metastases from breast and lung tumors are the most common occurrence. They tend to locate near the vascular portion or the uveal tract near the macula. Up to 50% of patients who present with ocular metastasis have no history of primary tumor. There are bilateral ocular metastases in one-third of the cases. On CT, ocular metastases typically appear as noncalcified thickened areas of increased density that may enhance. These lesions can be associated with subretinal fluid[5]. Idiopathic sclerochoroidal calcification is a disease of older men as opposed to retinoblastoma, a disease of children. Phthisis bulbi is associated with a small globe and blindness whereas idiopathic subchoroidal calcification has a normal size glove and is asymptomatic.

Intraocular mineral deposition may occur secondary to ossification or calcification. Three types of calcifications are dystrophic, metastatic, and idiopathic. Dystrophic calcifications in which there is deposition of calcium in abnormal tissue with normal serum calcium and phosphorus, can be seen secondary to trauma, inflammation, retinoblastoma, Coat disease, or senile degeneration of the sclera[3]. Metastatic calcification where the deposition of calcium in normal tissue secondary to abnormal elevation of the serum calcium and phosphorus occurs in hypercalcemic states such as hyperparathyroidism, psuedohypoparathyroidism hypervitaminosis D, sarcoidosis, hypophosphatemia, and chronic renal failure.

Idiopathic sclerochoroidal calcification is characterized by bilateral calcified elevated choroidal lesions located in the superotemporal arcade in asymptomatic patients with otherwise normal fundi. The calcifications are thought to be typically located near the insertions of the medial or lateral recti[6]. The lesions are usually found incidentally in older men (aged 51-86 years) with normal visual acuity[5]. This entity is a diagnosis of exclusion, computed tomography may be helpful to detect contralateral funduscopically occult calcified lesions in patients initially thought to have unilateral disease. **MoMed**

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Members In The News

Patricia L. Barker, MD, Hannibal, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Hannibal Regional Hospital.

Dr. Barker is among a national network of over 1,800 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities.

Ronald G. Evens, MD, St. Louis, has been appointed president of Barnes-Jewish Hospital and senior executive officer of BJC Health System.

"Dr. Even's expertise in healthcare administration and finance, as well as in the practice and teaching of medicine, uniquely qualify him to continue the excellent work of this nationally renowned hospital," says **William H. Danforth, MD,** co-chairman of the board of directors of Barnes-Jewish Hospital.

Michael A. Kass, MD, St. Louis, has been named head of the Department of Ophthalmology and Visual Sciences at Washington University School of Medicine. With the new appointment, he also becomes ophthalmologist-in-chief at Barnes-Jewish Hospital.

The appointment was announced by **William A. Peck, MD,** executive vice chancellor for medical affairs, dean of the School of Medicine and president of Washington University Medical Center.

AMA Physician's Recognition Awards

The following physicians have completed 150 hours of continuing medical education within a three-year period. Sixty of the credit hours are earned in Category 1 programs.

William J. Brian, *Springfield*
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Philip G. Pettett, *Kansas City*
Kimberly A. Russell, *Kansas City*
L. Michael Silvers, *Kansas City*
Steven J. Taylor, *Mexico*

Ramesh R. Shah, MD, has been inducted as a fellow of The International College of Surgeons. Dr. Shah is a retina surgeon in practice in Joplin and Carthage. He has led missions to India for eye surgeries for the past 14 years and has trained several ophthalmologists in India during his mission trips.

In Memoriam

Rolf E. Gryte, DO, 54, Osage Beach, died September 11, 1999. Dr. Gryte was an allergist and a member of the Missouri State Medical Association.

Guerdan Hardy, MD, 93, St. Louis, died September 7, 1999. Dr. Hardy was an otolaryngologist and a member of the Missouri State Medical Association.

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Journal of the Missouri State Medical Association December 1999

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On the Cover: Larry Jennings works at The Ovid Bell Press Inc. in Fulton, Missouri, where *Missouri Medicine* is printed. He is a self-taught artist who creates fictional places by embellishing actual settings.

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Working with Congress

J. Regan Thomas, MD

As the political campaigns intensify over the next year, more attention is going to be paid to the legislative process. I'm sure a number of issues that affect medicine will be in the spotlight including, for example, the "patients' bill of rights" concept. Although we should be active in the political process every year, it is understandable that we pay more attention during election periods because of the additional media attention. It may be helpful to make some suggestions on how to effectively get your message across at the congressional level.

Step one is to review those things you probably ignored in high school civics class. Here is how it works in brief. For a bill to get through Congress, it must maneuver through two key realities. The first is the Congressional system for delegating or distributing its work, and second is the critical mass or volume pending before Congress that session. Legislation falls into three basic categories: "entitlements" legislation (i.e. Medicare); "appropriations" bills (which provide funding for programs); or "authorizing" legislation (creates new federal programs or continues existing programs).

A bill is developed (usually by staff and advocates of the bill) and/or introduced officially by a member of Congress. Bills in the Senate are assigned an "S" number, and those in the House are designated with an "H.R." number.

The Congressional Committee system is where it becomes more confusing but where much of the legislative process is accomplished. Lawmakers rely on the committees to study the bill and its issues, collect facts, interact with the partisan politics of the bill and determine how issues should be resolved. There are 19 standing committees in the House of Representatives and 17 in the Senate. Most of the committees further delegate work into subcommittees who answer back to the "full committee" (or parent standing committee). The committees have considerable power as to whether a bill will proceed on through the remaining legislative process. You have, of course, heard of bills "dying in committee."

If a bill makes it through the subcommittee and is approved by the full committee, it is passed on to the House or Senate floors for debate. There it is defeated, passed, or amended. Frequently the House and Senate may pass different versions of the bill. Representatives from each group are selected to become a "conference committee" and attempt to work out a compromise. This should end in a "conference report" which sends forward a compromise bill for the House and Senate to consider. If both chambers approve of the compromise, the bill then goes on to the President to approve or veto.

With that review of "things you should have learned in school had you been paying attention," it is important to realize that your influence and impact depends a lot on timing. There are points along the way of the legislative journey where you can interact with greater ability.

It should be no surprise that the earlier you get involved with the process the better. Once you are reading about it in the newspaper it is well along in the process and difficult to modify. Congress often groups several issues into one "omnibus bill" which makes it more difficult to change at a late date. So, if possible, you should get active at the front end of the process and discuss your opinions and concerns when the bill is being developed by a legislator's staff.

The next point where you can be effective realistically is at the committee level. Again, the earlier in this process that you make contact with your legislator, the better. Early in the committee review stage, the committees welcome input from interested individuals or groups. Visits and letters can have significant influence at this stage. Even if your own Senator or Representative is not a member of the committee, they can be an active advocate of your position on a bill and influence their colleagues on the committee.

From this point on it becomes increasingly difficult to influence a bill. However, as the bill comes up for floor debate, communication with the Senator or Representative can by very helpful in determining their vote on the issue. Most "staffers" feel that communication about legislation coming up for floor debate should come as close to the time of voting as possible. This is a place where an organized, coordinated response from a given constituency is particularly helpful.

If the bill goes to conference (and most do) it is usually only there a few days, so again timing is important to try to influence the vote of the conference members. By the time the bill goes to the President, the decision to approve or veto has typically already been decided in advance. That's the time when you are reading about it in the newspaper and perhaps wish you had been more active earlier in the process!

A last point is to realize the importance of working with the staff in your Senator's or Representative's office. Staff has considerable influence on the elected representative's opinions and decisions. Often they are doing the actual research and influencing the content of legislation. All elected officials at this level have legislative aids and staff personnel who typically craft much of that official's response to any given issue. Developing positive relationships with those staff members will be an important part of your success in the legislative process. **MoMed**

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President's Page

Focusing Public Interest

William Dorzab, MD

Physicians are uniquely qualified to recognize threats to patient care. Medicine is complicated. It has not been easy for the lay public, including most legislators, journalists and our patients, to appreciate how managed care's single-minded emphasis on cost would devastate the sick. Indeed, even those who are injured by poorly conceived managed care decisions do not constitute a large enough group to be obvious to casual observers.

How well I remember those darker days. Physicians consoling one another in Doctor's Lounges, lamenting the harm to their patients, but seeing no immediate solution. Physicians were independent practitioners, isolated members of a "cottage industry," under assault by a larger, better-organized enemy. To be sure, they held the "high ground," but how long would it take until others could understand what physicians knew? How long before public opinion would become an ally?

The passage of time has been excruciatingly slow. Patients have been inconvenienced, even injured. But, we are finally home. Managed care has been exposed for what it is. Not managed care at all, but rather managed finance and payment bent upon maximizing profits to its shareholders and minimizing "medical loss ratios" (that measure of the cost of care provided to the sick, so abhorrent to managed care companies).

Oddly, this lack of interest in patient welfare is as it should be. Corporations have no ethics. They have no long-standing principles, demanding service to the sick. They only have fiduciary responsibility to their shareholders. There was never any reason to expect any other behavior (unless one were naive enough to believe their transparent, high cost, public relations campaigns).

Public repulsion against managed care has been impressive. Radio talk shows, nightly news programs, Hollywood movies, comic sections of newspapers, state and federal legislature debates, platforms of political candidates and newspaper editorial boards are all burgeoning with interest.

Many of these like to think they lead public opinion. Actually, it is often the other way around. This is particularly evident in the cases of elected and wishing-to-be-elected public officials. They sense the change in public sentiment. During the fall I witnessed a veritable "feeding frenzy" of activity, both in Washington and in Missouri. Legislators and candidates for office, from those aspiring to be President of the United States on down to state office. Everyone wanted to be identified with our effort to disabuse patients of managed care's excesses.

What a deep satisfaction this is for physicians. We have waited so long for public awareness to catch up. Physicians must seize the opportunity and take advantage of this window of opportunity in the political process. Communicate with your state and federal senators and representatives. Attend candidate benefits. Write letters to newspaper editorial boards. Talk to your patients and encourage them to become active in the fight.

Make sure everyone knows you will accept nothing short of medical marketplace regulation that will give patients the power to choose their physicians and to make decisions with that chosen physician about the care they will receive. Also make sure that anyone, including managed care organizations, who interferes with medical decision making, must answer, in court if necessary, for the injuries they cause.

What's a good way to get started? The House/Senate Conference Committee on the Managed Care Improvement Act of 1999 (H.R. 2723, Norwood-Dingell Bill) and the Senate version is expected to meet early in 2000. Many believe the membership of the Committee has been carefully chosen by the leadership to tilt the process away from Medicine's position.

Patients and the Profession need a massive effort by physicians and their patients. Send the message to Washington:

We will accept nothing less than the strong improvements embodied in the Norwood-Dingell bill.

Take the time to discuss the issues with your patients. Make sure they know how to send their own messages. Together, we can use the momentum we enjoy to leap forward into a better tomorrow. The long wait is over at last. MoMed

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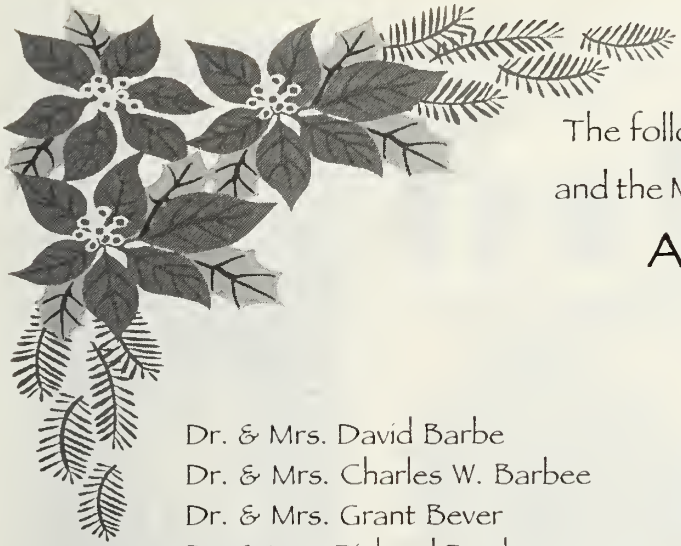

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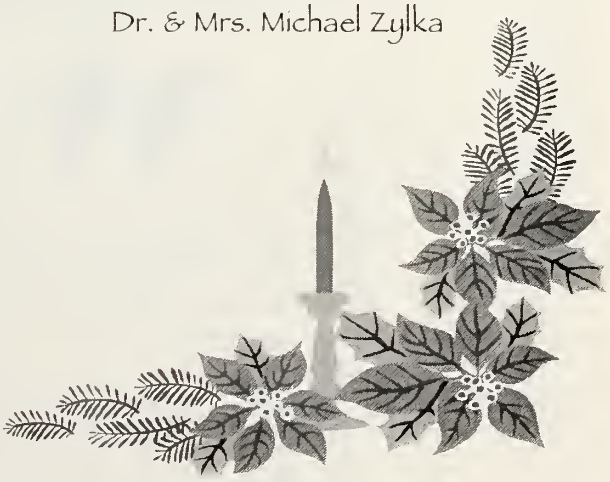

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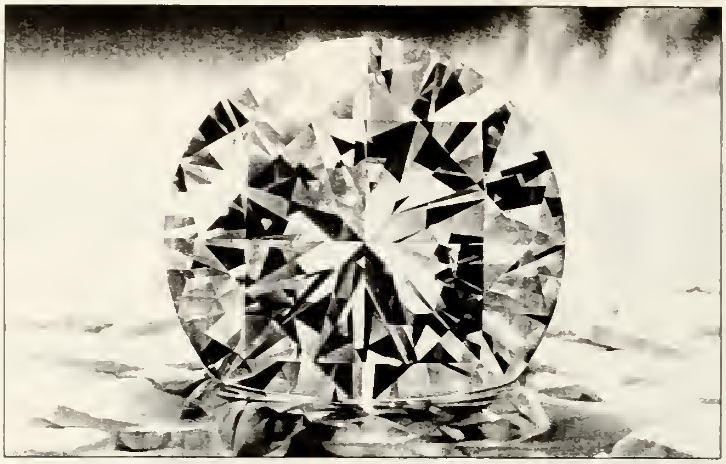

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Taking Care of Cancer Patients; Beyond Science and Technology

S. D. Madduri, MD

"I heard my doctor say, 'I am sorry, the test results show that you have cancer.' I heard nothing else. My mind went blank and then I kept thinking, 'No, there must be some mistake.'"

The words, 'you have cancer' can have dramatic and devastating effects, evoking a wide range of feelings: shock, denial, anger, guilt, shame, anxiety, depression, confusion, uncertainty, doubt, and fear. They usher in a world of bewildering choices - endless surgeries, radiation and chemotherapy treatments, health maintenance, financial burdens, and changing personal relationships, to name a few.

For many cancer survivors the most difficult aspect of the disease is coping with the accompanying emotional distress. Uncertainty about tomorrow, frustration and anger with the "why me?" feelings, job and employment issues, relations with family and friends, feelings of helplessness and fatigue, and financial worries can overwhelm cancer victims and make them physical and emotional cripples.

When the initial shock wears off, most people with a diagnosis of cancer are able to develop a sense of hope that helps them get through the illness. It is well documented that patients who acquire this "hope" and positive attitude toward their illness generally fare better than those who don't, and in many cases experience a successful outcome. It has also been shown that a positive attitude and a hopeful outlook may improve the immune system, giving it a better chance to fight cancer, and enhancing the quality of life. As the person involved in the patient's diagnosis, subsequent treatments, management of complications, and emotional well-being, the physician plays a major role in the patient's prognosis and final outcome.

Physicians practice the "healing arts."

But without the elements of empathy, the physician will not be complete, and his or her clinical skills and technical expertise may fall short.

The difficult task of cancer treatment starts with informing the patient of the diagnosis. One of the most unpleasant tasks a physician may face is to tell a patient he or she has cancer. More so if one has to inform the patient via telephone. Results given over the telephone should not be a short, matter-of-fact, "Hi, your tests showed you have cancer; come by my office and I will tell you what is next." The physician must realize he or she is not talking about strep throat; the patient has cancer, a life-threatening disease. A detailed explanation of the disease process with reassurance that therapy is available to induce remission or even cure the disease will relieve some of the patient's worries. Hopeful outlook with success stories of modern treatment methods should be an established norm from day one.

Statistics and averages can cause unnecessary worry. Statistics are based on a very complicated analysis of thousands of cases, and the same kind of cancer doesn't always behave the same in two different patients. The way the statistics are presented will make a significant difference. Instead of telling a patient he or she has a 15% five-year mortality, the same fact can be presented in a more positive fashion by saying there is an 85% chance of a five-year survival. It's also important to remember that cancer patients hate to hear the words death, advanced stage disease, poor prognosis, etc. I distinctly remember a physician who, during his everyday rounds following a major cancer surgery, told the patient and the family that the surgery carried a 20% mortality rate, and when the patient developed postoperative thrombophlebitis the mortality rate increased to 50%! The patient's family grew so tired of the physician's pessimistic demeanor, they signed the patient out of the hospital, not to be seen there again.

"My cancer treatment ended 10 years ago, but I still get anxious every time I go in for a check up," says a patient. Experts agree that it is a common reaction. Waiting for a test result is an ordeal, and experiencing new pain or noticing a bump can be very frightening. Anxious patients often take these as a sign of recurrence. Treating a cancer patient is time consuming and requires compassion. One negative or careless remark regarding the disease may tip them off balance and cause devastating long-term results.

One of my physician friends, who also is a cancer patient, talks about his oncologist. "I don't know if he (oncologist) is exaggerating the facts about my prognosis, but he makes me feel good. Every time I visit him, I come out with new hope." Physicians who do not have the necessary time and compassion should refrain from treating cancer patients. An unfriendly, business-like attitude can cause the patient more harm than good. Cancer therapy is one discipline where economics should not impede proper management. HMOs, PPOs, and DRGs should not dictate the time a physician spends with the patient. Likewise, they should not limit any necessary tests or therapies.

Medicine, both a science and an art, is best exemplified in the care of cancer patients. We are taught at length the science of medicine during medical school. But it is up to the practicing physician to develop the caring attitude that contributes to the patient's well-being. Physicians practice the "healing arts." But without the elements of empathy, the physician will not be complete, and his or her clinical skills and technical expertise may fall short. The practice of medicine, particularly oncology, goes far beyond science and technology. **MoMed**

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Initial Experience with the MONARCH ™ IOL Delivery System for Insertion of the 5.5 mm. ACRYSOF® Intraocular Lens

John C. Hagan, III, MD

SYNOPSIS-ABSTRACT

This paper reports the initial 100 clinical cases with the *MONARCH*™ IOL Delivery System ("the Monarch") for insertion of a 5.5 mm ACRYSOF® foldable intraocular lens (IOL) into the capsular bag following small incision cataract surgery by phacoemulsification. There were no cases of capsular tears, vitreous loss, IOL dislocation or decentration or placement outside the capsular bag. There was one case of haptic entrapment within the cartridge requiring use of a second IOL and cartridge. There was one case in which the surgeon placed the IOL in the wrong anterior-posterior direction requiring a 180 degree re-orientation. The *MONARCH*™ IOL Delivery System is extremely convenient, reliable and is highly recommended.

REPORT OF STUDY

A new proprietary foldable IOL inserter (figures 1 and 2) has recently become available. The device is called the *MONARCH*™ IOL Delivery System, "the Monarch" and is used to insert the 5.5 mm. Alcon ACRYSOF® acrylic intraocular implant (Model MA30BA)[1] into the capsular bag. This study describes the use of the Monarch and summarizes my first 100 implantations of ACRYSOF implants with the device.

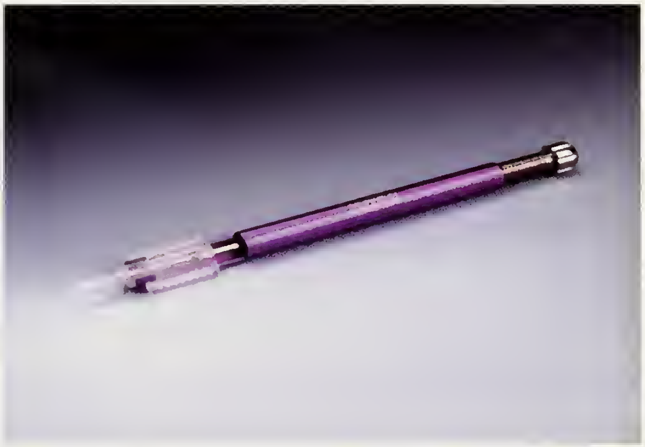


Figure 1. The Monarch consists of a reusable, sterilizable titanium handpiece and a single use sterile insertion cartridge.

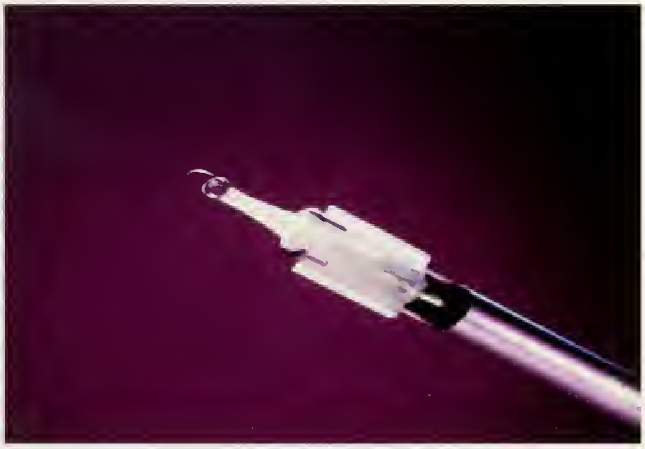


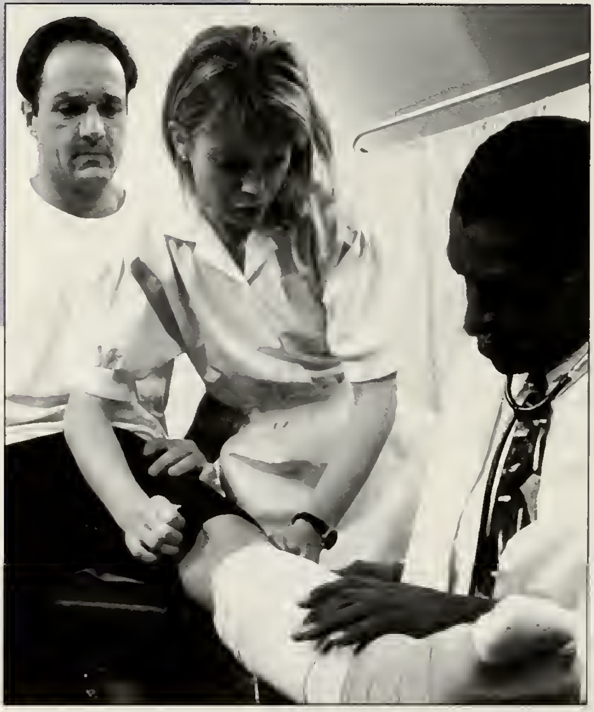
Figure 2. A 5.5 mm ACRYSOF IOL is being extruded from the tip of the cartridge by the central plunger.

DESCRIPTION OF INSTRUMENT AND INSERTION TECHNIQUE

The Monarch (Figure 1) consists of a reusable, sterilizable titanium handpiece and a single use sterile insertion cartridge. At present only the 5.5 mm Alcon MA30BA acrylic ACRYSOF foldable IOL can be inserted with the Monarch.

(continued on page 561)

The Power of Relationships



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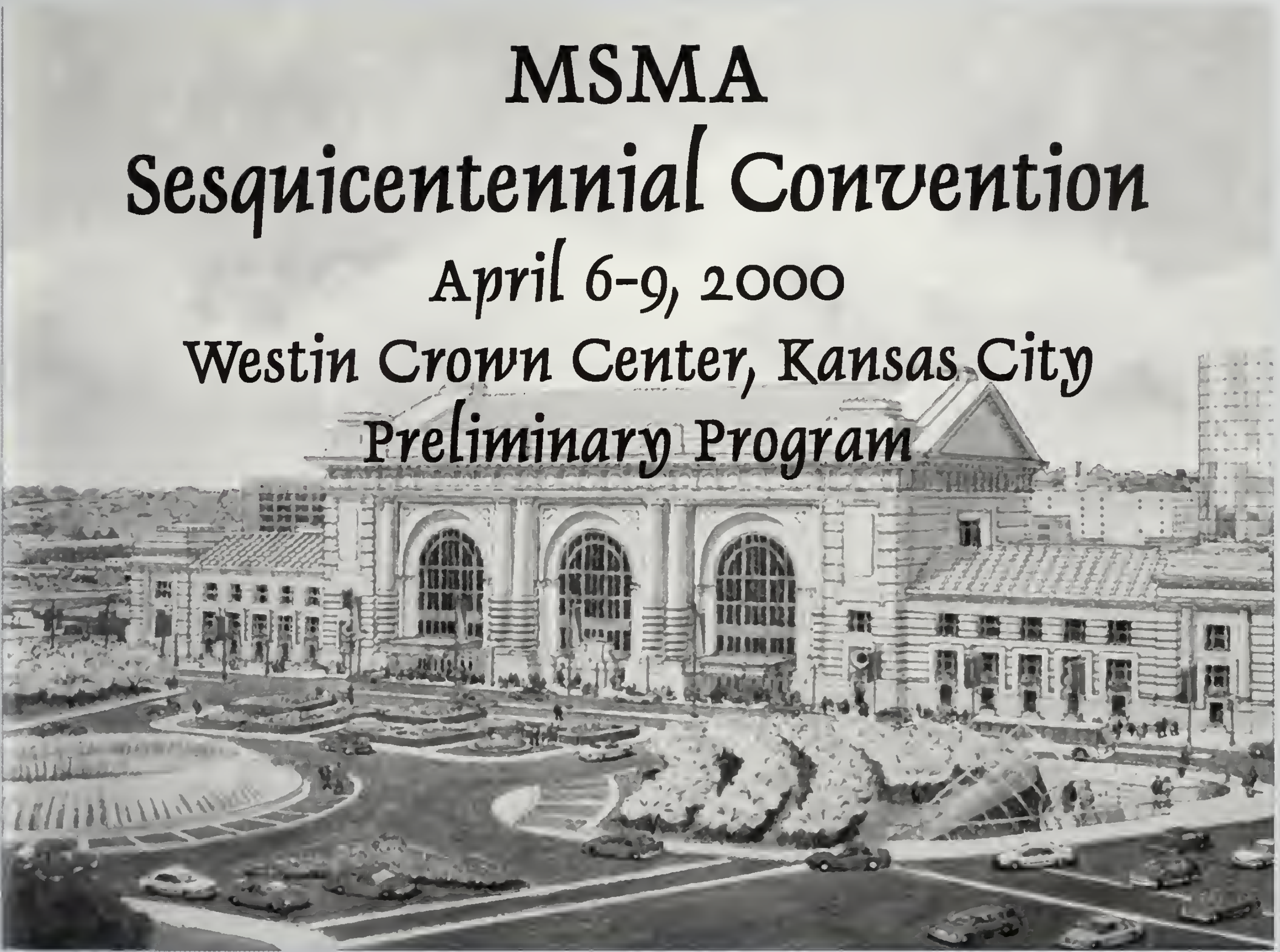
MSMA
Sesquicentennial Convention
April 6-9, 2000
Westin Crown Center, Kansas City
Preliminary Program



Kansas City's restored Union opened as the home of Science City in November 1999.
Physicians will have the opportunity to visit Union Station while attending
Missouri State Medical Association's 2000 Annual Convention.
Please mark your calendar and plan to join us as MSMA takes medicine
into the new millenium and celebrates its 150th anniversary along
with the MSMA Alliance celebrating its 75th anniversary.

1850-2000 **MSMA**
Sesquicentennial
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MISSOURIANS FOR 150 YEARS

1924-1999
75 Years of Caring
Missouri State Medical Association Alliance
PHYSICIANS' SPOUSES DEDICATED
TO THE HEALTH OF MISSOURIANS

Preliminary Program

MSMA Sponsored Events

April 6, Thursday

2:00 pm	Opening Session, MSMA House of Delegates
4:00 pm	Reference Committees Meeting

April 7, Friday

7:00 am	Councilor District Breakfasts
7:30 am	Physicians Health Committee Meeting
8:00 am	Opening General Session
10:00 am	General Session
11:00 am	Open Forum on AMA Issues
11:00 am	Medical Student Luncheon
4:00 pm	Second Session, MSMA House of Delegates

April 8, Saturday

7:00 am	Missouri State Medical Foundation Board Meeting
7:00 am	Young Physicians Section Breakfast Meeting
8:00 am	General Session
11:00 am	MMPAC Meeting
1:00 pm	International Medical Graduates Meeting
1:30 pm	General Session
3:15 pm	General Session
6:30 pm	Presidential Inauguration
7:30 pm	Reception

April 9, Sunday

7:30 am	Final Session, MSMA House of Delegates

Component Medical Societies

April 6, Thursday

noon	St. Louis Metro Luncheon
noon	Metro Med of Greater KC Luncheon

April 7, Friday

7:00 am	Councilor District Breakfasts
noon	Metro Med of Greater KC Luncheon
2:00 pm	St. Louis Metro Caucus

Other Events

April 6, Thursday

6:45 am	Moneta Breakfast

April 7, Friday

7:30 am	UMC Alumni Board of Governors Breakfast Meeting
12:00 pm	UMC Alumni Luncheon
6:00 pm	Alumni Receptions

Exhibits

April 7, Friday

8:00 am	Coffee and Rolls in Exhibit Hall
10:30 am	Intermission to View Exhibits
2:00 pm	Intermission to View Exhibits

April 8, Saturday

8:00 am	Coffee and Rolls in Exhibit Hall
10:30 am	Intermission to View Exhibits

MSMA Sesquicentennial Convention General Sessions

- Election 2000: Candidate Forum
  (Friday, 8:00 am)
- Educating Physicians about End-of-life Care (EPEC) Project
  (Friday, 10:00 am)
- Unions - Collective Bargaining
  (Saturday, 8:00 am)
- EMTALA Regulations (Emergency Medical Treatment and Active Labor Act)
  (Saturday, 1:30 pm)
- Risk Management
  (Saturday, 3:15 pm)

CONVENTION DEADLINES

January 21
Community Service Award Nominations

February 6
Delegate Credential Cards

February 21
Resolutions

Celebrating 150 Years at the 2000 Convention

Specialty Societies

April 7, Friday

9:45 am	Missouri Dermatological Society Program
11:00 am	Missouri State Surgical Society Program
2:00 pm	Missouri Society of Otolaryngology- Head and Neck Surgery Program
2:00 pm	Missouri State Surgical Society Program
6:00 pm	Missouri Society of Anesthesiologists House of Delegates and Reference Committee
6:00 pm	Missouri Chapter, ACP-ASIM Program
6:30 pm	Missouri Academy of Family Physicians Dinner Board Meeting

April 8, Saturday

7:00 am	Missouri Association of Plastic & Reconstructive Surgery Board Meeting
7:00 am	Missouri Society of Otolaryngology - Head and Neck Surgery Breakfast Board Meeting
8:00 am	Missouri Society of Radiology Breakfast Meeting
9:45 am	Missouri Dermatological Society Program
9:45 am	Missouri State Neurological Association Program
10:00 am	Missouri State Surgical Society/Missouri Chapter, American College of Surgeons Program
10:00 am	Missouri Society of Anesthesiologists Program
10:00 am	Missouri Society of Otolaryngology - Head and Neck Surgery Program
10:00 am	Central Society of Physical Medicine and Rehabilitation Luncheon
10:00 am	Missouri Association of Plastic & Reconstructive Surgery Program
11:00 am	Missouri Society of Radiology Program
11:30 am	Central Society of Physical Medicine and Rehabilitation Program
11:30 am	American Cancer Society Liaison Luncheon
noon	Missouri Association of Plastic and Reconstructive Surgery Luncheon
noon	Missouri Society of Anesthesiologists Luncheon
noon	Missouri Society of Radiology Luncheon
12:15 pm	Missouri Society of Otolaryngology - Head and Neck Surgery Luncheon
1:00 pm	Missouri Society of Radiology Program
1:00 pm	International Medical Graduates Program
1:30 pm	Missouri Society of Anesthesiologists Program
1:30 pm	Central Society of Physical Medicine and Rehabilitation Program
1:30 pm	Missouri Association of Plastic and Reconstructive Surgery Program
3:00 pm	Missouri Society of Anesthesiologists Second House of Delegates

April 9, Sunday

9:30 am	Christian Medical and Dental Society Program

MSMA Alliance

April 6, Thursday

10:00 am	Board Meeting
noon	Past Presidents Luncheon
3:00 pm	General Assembly, Session I
7:30 pm	An Evening of Kansas City Hospitality

April 7, Friday

9:00 am	General Assembly, Session II
10:00 am	MSMA/MSMAA General Session
11:00 am	General Assembly, Session III
7:30 pm	AMA Foundation Fundraiser

April 8, Saturday

8:30 am	General Assembly, Session IV
noon	Installation and Awards Luncheon
3:00 pm	Joint Convention Board Meeting
6:30 pm	Presidential Inauguration
7:30 pm	Reception

CELEBRATING 150 YEARS AT THE 2000 CONVENTION

MISSOURI STATE MEDICAL ASSOCIATION
SESQUICENTENNIAL CONVENTION

APRIL 6-9, 2000
WESTIN CROWN CENTER
KANSAS CITY, MISSOURI

PREREGISTRATION

Registration for MSMA's Sesquicentennial Convention is *easy!*
FAX: Registration form to 573-636-8552
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INTERNET: Register over the Internet at *www.msma.org.*

Name

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City/State/Zip

Delegate ☐ *Member* ☐ *Non-Member* ☐

Daytime Phone Number

Medical Specialty *Component Medical Society*

Upon receipt of your preregistration, you will be mailed a confirmation card to present at the Sesquicentennial Convention registration desk. Your registration packet and name badge will ready for pick-up.

Check the sessions you will be attending:

_____ *Election 2000: Candidate Forum*
_____ *EPEC (End-of-Life-Care)*
_____ *EMTALA Regulations*
_____ *Unions-Collective Bargaining*
_____ *Medical Specialty Programs*

HOTEL RESERVATIONS

MISSOURI STATE MEDICAL ASSOCIATION
Sesquicentennial Convention ◆ April 6-9, 2000

Reservations for the Westin Crown Center must be made by **FEBRUARY 21, 2000,** to take advantage of MSMA convention room rates.

TO MAKE RESERVATIONS:

CALL Westin Crown Center at 816-474-4400 with any major credit card

FAX Fax the form below to 816-391-4493, ATTN: Caroline

MAIL Mail the form below to Westin Crown Center, #1 Pershing Road, Kansas City, MO 64108

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Non-Smoking _____ *Smoking* _____ *Special Needs* _____

Reservations are accepted on a space-available basis, so please make your hotel reservation as soon as possible. Reservations will be accepted and confirmed up to the opening day of the Convention, providing accommodations are still available. Reservations run from 4:00 p.m. on day of arrival until noon on day of departure.

Cancellation Policy: The Westin Crown Center requires an advance of one night's lodging or credit card guarantee to confirm reservations. Deposits are refunded/credited only when cancellation reaches the Westin Crown Center office 24 hours prior to day of arrival. Your deposit will be forfeited if you arrive later. To avoid penalty for early departure, 48 hours notice must be given. This form may be duplicated.

(continued from page 555)

The recommended technique[2] for loading and implantation of the ACRYSOF with the Monarch is as follows:

1. After inspection, the cartridge is filled with VISCOAT® or other Alcon qualified viscoelastic (Figure 3).

2. Inspect the ACRYSOF intraocular implant and using holding forceps carefully grasp the optic edge. Insert the IOL anterior side up into the back of the cartridge (Figure 4). The top of the cartridge has an outline of the proper orientation and position of the implant.

3. The lens is inserted until it lies just below the corresponding etched outline and is in the same directional orientation.

4. The blades of the forceps are closed and inserted into the rear of the cartridge over the optic. Gentle, even, downward pressure is applied across the top of the optic (Figure 5). This positions the implant in the bottom of the cartridge and helps the anterior folding of the optic.

5. The IOL loaded cartridge is then placed into the handpiece with the plunger fully retracted. The cartridge is slid forward and will snap into place with a palpable and audible snap (Figure 6).

6. The handpiece plunger is advanced forward to contact the implant. The trailing haptic must be positioned ***UNDER*** the plunger. If it is not under the plunger as it contacts the optic then forceps can be used to place the trailing haptic in the proper position. When the threads of the plunger engage the handpiece the implant is further advanced by clockwise rotation of the plunger. The lens plunger should not be retracted during the procedure or lens damage may occur.

7. The implant is advanced to the tip of the cartridge making sure that the plunger tip remains behind the optic and that the leading haptic is looped in front of the optic.

(continued on page 562)

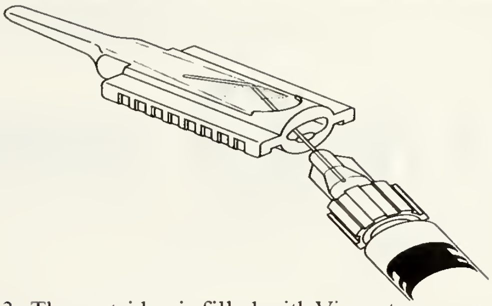

Figure 3. The cartridge is filled with Viscoat.

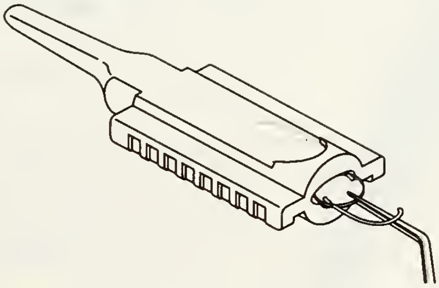

Figure 4. Holding forceps are used to grasp optic edge and insert the IOL in the back of the cartridge.

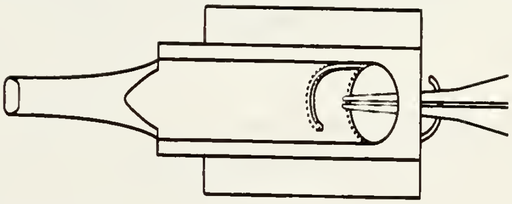

Figure 5. The IOL is inserted until it lies just below the IOL outline etched in the top of the cartridge. Closed forceps are placed over the optic and pressure applied downward.

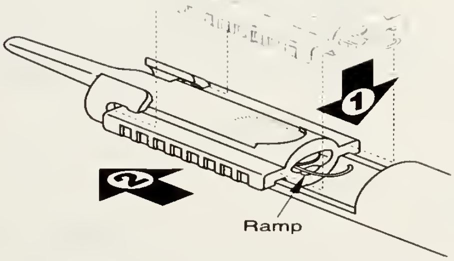

Figure 6. The IOL loaded cartridge is placed in handpiece with plunger retracted. Moving the cartridge forward snaps it into place. The plunger is moved forward to contact the ramp.

8. The tip of the cartridge is placed through the surgical incision and positioned at the anterior capsular opening.

9. As the plunger is turned to advance the implant the Monarch handpiece is rotated clockwise approximately 60 to 90 degrees to insure insertion in the proper anterior side up position.

10. As the lens is further extruded from the tip the Monarch handpiece is rotated counter-clockwise, up to 180 degrees, moving the bevel to the right to maintain proper orientation of the leading haptic.

11. When the plunger is fully engaged and/or the IOL is extruded except for part of the trailing haptic the cartridge nozzle tip is withdrawn from the incision making sure the trailing haptic exits from the tip.

12. The implant should be in such a position that the open side of the leading haptic is facing left and that the IOL is rotatable clockwise after the trailing optic is placed in the capsular bag i.e. right-handed rotation.

13. The trailing haptic is placed in the bag with a forceps or lens positioning instrument.

PATIENTS AND METHODS

I prospectively tabulated the results of my first 100 consecutive ACRYSOF IOL implantations using the Monarch IOL Delivery System. I began in March, 1999. My small incision cataract surgical technique has been described.[3] Prior to switching to the ACRYSOF I had used a 5.5 mm. three piece all PMMA IOL. The patients were a consecutive series from my private practice. The implant was inserted through a 3.5 mm. two-plane, self-sealing opening at the limbus.

RESULTS

All IOLs were successfully placed in the capsular bag. There were no complications during phacoemulsification or the insertion process. Specifically there were no cases of capsular tears or ruptures, no splits or rents in the capsulorhexis, no stripping of Descemet's membrane and no bleeding or vitreous loss. In one case the implant was inserted backwards with a left hand or counter-clockwise rotation position. The anterior side of the optic was posterior. The IOL was rotated to the proper position with forceps. This was my fourth Monarch case and due to my inexperience, not the fault of the instrument. Post-operatively there was no infection, bleeding, lens dislocation or wound leak.

DISCUSSION

The advantages of the Monarch system include less manipulation and better control than with folding and insertion forceps. The Monarch system is completely enclosed and prevents any part of the implant from touching structures exterior to the eye. This should aid sterility and reduce the risk of infection. Delivery is slower, more controlled and easier to learn than with insertion forceps. The instrument is sturdy, reliable and easy to maintain. Optic scuffing and marking should be less than with forceps.

Because of the posterior angulation of the implant it is important to insert the implant in the proper anterior-posterior orientation. If the IOL is placed with the posterior optic surface forward the focal point will be moved anterior to its expected placement making the eye more myopic than desired.

MoMed

ACKNOWLEDGEMENTS

The author wishes to acknowledge Alcon Surgical for the photographs and illustrations used in this study and North Kansas City Hospital for their longstanding support of Ophthalmic Surgery.

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1. Oshika T, Suzuki Y, Kizaki H. Yaguchi S. Two Year Clinical Study of a Soft Acrylic Intraocular Lens. *J Cataract Refract Surgery* 1996; 22:104-109.
2. *MONARCH®* Instructions for Use. ACR181 Alcon Surgical. 1999; Fort Worth, TX.
3. Hagan III JC, Davison JA. A Clinical Study Comparing the Alcon Series 20,000 Legacy to the 10,000 Master Phacoemulsifier, *J Cataract Refract Surgery* 1998; 24:693-696.

MSMA Medical Students

Sharpen Your Quills

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Win $100 *& Publication in Missouri State Medical Association's Medical Journal*

Submissions due by: December 31, 1999
First Prize: $100 and publication in *Missouri Medicine.*

All MSMA medical student members can enter essay contest. All forms of prose and the topic of your choice will be accepted. Submit hard copy and disk in WordPerfect/Word format. Indicate article as Essay Contest Submission. Use correct grammar, punctuation and double-space article. Limit words to 1,000-1,500 per article. Students can enter more than one article. One entry per disk. Submissions and disks cannot be returned. Only one winner will be chosen. Winner and article will be announced and published in a Spring edition of *Missouri Medicine.*

Send to: Becky Jungermann, Managing Editor, *Missouri Medicine*, MSMA, 113 Madison Street, P.O. Box 1028, Jefferson City, MO 65102. For questions, call 573-636-5151 or E-Mail at bjungermann@msma.org.

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René La Ferla
Legal Assistant

October 27, 1999

Dear Missouri Doctor:

For the past 16 years, I have observed many instances when physicians, surgeons and hospitals were uncompensated or poorly compensated for the services provided to accident victims. I have found that too frequently, accident victims are uninsured or ineligible for Medicaid coverage.

There are solutions beyond the traditional collection agency.

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Your or your staff's call to my toll-free number above will be received courteously. I will personally address these cost-free inquiries of how my techniques can help your practice. There is no obligation.

Sincerely yours,

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Take Advantage of MSMA's Newest Membership Benefits

MSMA Program Cuts Malpractice Premiums

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The program provides two major benefits:

1) members pay less for their malpractice insurance;

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MSMA is assisted in this program by Healthcare Insurance Services (HIS), an insurance broker from Houston, Texas specializing in medical malpractice insurance. HIS acts as the insurance broker for approximately 40,000 physicians around the country. The company is lending its expertise to MSMA to insure the program combines high quality and low rates.

Los Angeles-based Farmers Insurance Group will underwrite the policies, something the business has done for 50 years.

According to Farmers, they will offer a minimum of 10-15 percent discount from what most physicians pay now. Farmers has assured MSMA it will meet or beat the rates now available.

If you are interested in receiving a bid to compare to your current premiums, call Tim Aguilar or Hal Kinsey of HIS at 800-733-4474.

Use MSMA's Contract Review Service

The Missouri State Medical Association has established a network of attorneys for the purpose of reviewing physician employment contracts. The four selected are:

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◆	Craig Van Matre	Van Matre and Harrison
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◆	Bill Mauck	Yates Mauck
	Springfield	417-883-7411
◆	David Patzman	Morrison Hecker
	Kansas City	816-691-2731

The above have significant experience in physician employment contracts and offer fair prices. Although they have been recommended by the MSMA, please note that we are not responsible for any advice rendered or acted upon.

Looking For a New Job?

Medical Employment Directory is a Missouri company specializing in physician placement that has recently been endorsed by MSMA. With five offices statewide, MED's four placement divisions include: physician recruitment, permanent placement, temporary staffing, and human resource consulting. Each personnel counselor is a medical professional with a knowledge of licensing requirements and certifications.

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MSMA is pleased to make available a tax-qualified MSA health insurance plan for physicians with self-employment income*. Below is an outline of how Golden Rule Insurance MSAs work to your advantage.

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. . . .

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6) At age 65, withdrawals for any non-qualified purpose are subject only to tax, not a penalty.

**You probably have self-employment income if: a) you are a sole proprietor; b) you are a partner in a partnership or Limited Liability Corporation; c) you own a greater than 2% share of a Subchapter S Corporation; or d) you are an owner of a Professional Corporation that has elected to be treated as a Subchapter S Corporation.*

Members In The News

The Missouri Chapter of the American College of Physicians - American Society of Internal Medicine recently presented **Warren Lovinger, MD**, the Laureate Award. This is an honor reserved for those within the profession who have demonstrated commitment to excellence in medical care, education and research as well as a commitment to serve the community in which they live.

During the annual business meeting of the Metropolitan Medical Society of Greater Kansas City, **Carl Strauss, MD**, received the Merit Award. Dr. Strauss is a Kansas City internist and a former Metropolitan Medical president.

A team of researchers at the University of Missouri - Columbia announced the formation of the MU Comparative Orthopaedic Laboratory. Researchers created the laboratory to find joint solutions for human and animal disease. It is the first one in Missouri and only the third of its kind in the nation. **Keith Kenter, MD**, assistant professor of orthopaedic surgery, is among those who have put their minds, research interests and resources together to open the new laboratory. The ultimate goal of the lab is to share information across the disciplines to treat, cure and eliminate the common and debilitating diseases affecting the joints.

Martin B. Wax, MD, associate professor of ophthalmology and visual sciences, received a one-year $12,339 grant from the Glaucoma Research Foundation for a project titled "Experimental Autoimmune Glaucoma in Rats."

In Memoriam

Paul Marshall James, Jr., MD, 66, Holts Summit, died Friday, October 8, 1999. Dr. James was a vascular surgeon and member of the Missouri State Medical Association.

Warford B. Johnson, Sr., MD, 85, Springfield, died September 16, 1999. Dr. Johnson was an internist and a member of the Missouri State Medical Association.

Clarence E. Mueller, MD, 83, O'Fallon, died Sunday, October 17, 1999. Dr. Mueller was an internist and a member of the Missouri State Medical Association.

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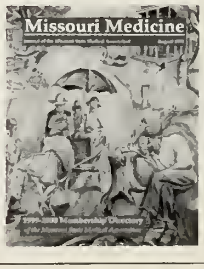
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